

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-142

04538 P

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County - Baltimore

City or town - Belvoir

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

8 west overlea ave.

Stay in hospital or inst. (yrs., or mos., or days) -

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

Maria Dell'Acqua

4. Sex 5. Color or race White Widowed

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Joseph Dell Acqua

7. Birth date of deceased (mo., day, yr.) Oct 1 1871

8. AGE: Years Months Days If less than one day
75.

9. Birthplace (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Louis Dell Acqua

Address 8 west overlea ave.

17. Burial Date thereof May 31-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Belair Road

18. Funeral director Ode's Funeral Home & Crem

Address 4644 York Rd #12

19. (Date rec'd by registrar) 5/28/46 A.W. Hedrick Registrar D.M.E.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County Baltimore

City or town Belvoir

Ward No.

Street No. 8 west overlea ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 27th 1946 et 19

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

no attending physician and that I last saw h alive on 19

Immediate cause of death

coronary thrombosis death rapidly

Due to

cystitis felonies 5 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident suicide or homicide Date

Where did injury occur? (City or town) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Approved by Robert E. Hudson M.D. D.M.E.

Address 11 Westover Ave. Date signed 5/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B.D.

04539

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

Baltimore

County

Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 8 mos., 17 days

Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 8 mos., 17 days

3. (a) FULL NAME

Mrs. Madeline Adams

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Charles Adams

7. Birth date of deceased (mo. day, yr.) August 10, 1916

6.(c) If alive, give age 35 years

8. AGE: Years Months Days If less than one day
29 9 15 .hrs. .min.

9. Birthplace Swansboro, North Carolina

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Cloud Howland

13. Birthplace Swansboro, North Carolina

14. Maiden name Lillie Dennis

15. Birthplace Swansboro, North Carolina

16. Informant Mrs. Madeline Adams

Address 18 Walker Ave., Pikesville, Md.

17. Burial Date thereof May 28, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Swansboro, North Carolina

Location Swansboro Cem., North Carolina

18. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. May 25, 1946 Earl Webster
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.

City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 Walker Avenue, Pikesville, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number
265-18-6333

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1946 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8, 1945, to May 25, 1946, and that I last saw her alive on May 25, 1946.

Immediate cause of death

Pulmonary Tuberculosis

DURATION
1 Yr.
9 Mos.

Due to Tubercle Bacilli

Due to

Other conditions Tuberculous Laryngitis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Stewart S Shaffer M.D. M.D. or other
Mount Wilson, Md. Date signed 5/25/46

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 26

04540

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 27 Yrs.
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Raymond Paine Allen

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Emily Barry Allen

7. Birth date of deceased (mo., day, yr.)..... Nov. 21, 1872

8. AGE: Years	Months	Days	If less than one day
73	5	10	hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Architect -Self

11. Industry or business

12. Name..... L.W.P. Allen
13. Birthplace..... Maryland

14. Maiden name..... Mary Porter Paine
15. Birthplace..... Virginia

16. Informant..... Raymond P. Allen Jr.
Address Apt. 16 B. Fenway South Balto. 21 Md.

17. Burial..... Date thereof May 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Druid Ridge Cemetery

Location..... Pikesville, Md.
18. Funeral director..... William J. Tickner & Sons
Address..... North & Pennsylvania Aves

19. Date rec'd by registrar..... 19 46
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town 7901 York Rd.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 1 19 46 at 6:00A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 15, 1946, to April 30, 1946, and that I last saw him alive on April 30, 1946.

Immediate cause of death..... Carcinoma (Bladder)
Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)
Major findings of operations..... Carcinoma of Bladder
Date of op. June 1945.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... John H. Green M.D.
M. D. or other.....
Address..... 511 N. Pennsylvania - 4th floor
Date signed..... 5/1/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B) 04541

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH

Baltimore
County
Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Vets. Adm., Fort Howard, Maryland

How long in hospital or institution?

3. (a) FULL NAME

AMONICA Frank

AMONICA

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

January 3, 1924

6.(c) If alive, give age..... years

8. AGE: Years

22

Months

4

Days

23

If less than one day

hrs. min.

Baltimore, Maryland

9. Birthplace

(town, county, and state)

Unemployed

10. Usual occupation

11. Industry or business

Vincent Amonica

12. Name

Italy

13. Birthplace

Adeline Delana

14. Maiden name

Italy

15. Birthplace

Clinical Records

16. Informant

Vets. Adm. Hesp., Ft. Howard, Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 29 1946

(Month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

Belair Rd., Baltimore, Md.

18. Funeral director

Frank Della Rose

Address

52 N. Morley St.

19. (registrar)

Baltimore, Md.

5/28/46

Death record

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County

State City or town

Baltimore Street

401 44 S. High Street

Street No.

World War II

2.(a) If veteran, name war

3. (b) Social Security Number

218-18-4654

MEDICAL CERTIFICATION

26th May

1946 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

13th May 1946 to 26th May 1946

and that I last saw him alive on

Immediate cause of death

Uremia, acute, severe

Due to Nephritis, chronic, parenchymatous, severe

DURATION

12 days

5 mos.

Due to

Secondary Anemia severe

Other conditions

(Include pregnancy within 3 months of death)

Blood Transfusion

Major findings or operations

5-20-46

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of:

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

Signature SAMUEL S. FRANKEL M.D. 5-26-46

VA, Fort Howard, Md. Date signed

Address

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48(B)

CERTIFICATE OF DEATH

14542

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				
County	Baltimore Co. Md.			
City or town	Dundelle			
(If outside city or town limits, write RURAL NEAR and give town)				
Street address, hospital, or institution:				
Stay in hospital or Inst. (yrs., or mos., or days) <i>None</i>				
Stay in this community (yrs., or mos., or days) <i>2 yrs</i>				
3. (a) FULL NAME <i>Alice K Anderson</i>				
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced <i>Single White Widow</i>		
6. (b) Name of husband or wife <i>Charles E. Anderson</i>				
7. Birth date of deceased (mo., day, yr.) <i>April 5 1876</i>				
8. AGE:	Years <i>70</i>	Month <i>1</i>	Days <i>14</i>	If less than one day hrs. min.
9. Birthplace	Balto Ind.			
(Town, county, and state)				
10. Usual occupation	<i>Housework</i>			
11. Industry or business				
MOTHER FATHER	John Maher			
12. Name	Balto Ind.			
13. Birthplace				
14. Maiden name	Alice Maher Nelson			
15. Birthplace	Balto Ind.			
16. Informant	Mrs. Viola Parker			
Address	7528 Carroll Avenue			
17. Burial	Date thereof (Burial, cremation, or removal. Which?) <i>Baltimore Cemetery June 1 1946</i>	(month)	(day)	(year)
Cemetery or crematory				
Location	End of E North Avenue			
18. Funeral director	Albert A. Higby Jr.			
Address	1601 1/2 Chester Street			
19. <i>5/31</i> (Date rec'd by registrar)	<i>X 6</i>	<i>A. W. Wedrich</i>	Registrar	<i>3 p.m.</i>

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
State	County	Baltimore County
City or town	Dundelle	Ward No.
Street No.	7528 Carroll Avenue	
(If rural give LOCATION)		
2(a) IF VETERAN, NAME WAR <i>No</i>		
3. (b) Social Security Number		

MEDICAL CERTIFICATION				
20. DATE OF DEATH	<i>May 29 1946 at 5:30 P.M.</i>			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <i>Feb. 1946</i> , to <i>May 29 1946</i> , and that I last saw her <i>alive on May 29 1946</i> .				
Immediate cause of death <i>Carcinoma of uterus</i>				
DURATION				
Due to				
Due to				
Other conditions <i>Attero-Sclerous</i> <i>Chronic myocarditis & nephritis</i>				
(Include pregnancy within 3 months of death)				
Major findings:				
Df operations				
Df autopsy				

22. VIOLENCE: If death was due to external causes, fill in the following:				
Accident, suicide, or homicide				Date of
Where did injury occur? (City or town)				(County) (State)
Injured at home, farm, industry, public place (where?)				
Means of injury				
Injured at work				
23. SIGNATURE <i>Walter A. Anderson</i>				
M. D. or other				
Address <i>300 Shamann Ave</i>				
Date signed <i>5/30/46</i>				

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-R

04543

P

CERTIFICATE OF DEATH

Reg. Dist. No.

4X

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frederick Appel.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife... Fannie

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

June 24 1886

8. AGE: Years Months Days If less than one day
59 10 7 hrs. min.

9. Birthplace..... Balto - Md.

(Town, county, and state)

10. Usual occupation..... Retired Police

11. Industry or business

Balto City

FATHER

12. Name..... Frederick Appel

13. Birthplace..... Germany

14. Maiden name..... Julia

15. Birthplace..... Balto - Md.

16. Informant..... Lorraine Appel (wife)

Address..... 621 Franklin Ave

17. Burial..... Date thereof..... 5/ 4/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Carmel

Location..... 21 Doneall Street Road

18. Funeral director..... Kelly & Zeila Inc.

Address..... 403 S. Wolfe St.

19. (Date rec'd by registrar) 5-2 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County

Balto.

City or town..... Essex

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1021 Franklin Ave
(If rural, give LOCATION)

2.(a) If veteran, name war..... No.

3. (b) Social Security Number

No.

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 1 1946, et 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

19.

and that I last saw h..... alive on

19.

Immediate cause of death..... Mononucleosis by gas

Due to..... Suffocation.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Suicide

Date of

Where did injury occur?..... Essex Ball, Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) At home

Means of injury..... Gas from stove

Injured at work?

Signature..... Dr. M. Garman M.D.

M. D. or R.N.

Address..... 1100 Park Ave

Date signed

Baltimore, Md. 5/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64544
36

Reg. Dist. No.

1. PLACE OF DEATH:

County... Baltimore

City or town... Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... Since April 26, 1940

Hospital, institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or institution?... Since April 26, 1940

3. (a) FULL NAME

ROBERT TAYLOR BAIR

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife... Mabel Kent Bair

7. Birth date of deceased (mo., day, yr.) September 10, 1880

8. (c) If alive, give age... 68 years

8. AGE: Years Months Days If less than one day
65 8 18 hrs. min.9. Birthplace Washington College, Wash. Co., Tenn.
(Town, county, and state)

10. Usual occupation Proprietor

11. Industry or business Lumber & automobile business

12. Name George W. Bair

13. Birthplace Virginia

14. Maiden name Mary Beard

15. Birthplace Tennessee

16. Informant HOSPITAL RECORDS

Address Sheppard-Pratt Hosp., Towson 4, Md.

17. Removal Date thereof May 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Keyser Funeral Home

Location Beckley, W. Virginia

18. Funeral director John Bacon, Son

Address Towson, Maryland

19. 5/29 1946 G. W. Bacon

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Raleigh

City or town Beckley

(If outside city or town limits, write RURAL and give nearest town)

Street No. 412 S. Kenawha St.

(If rural, give LOCATION)

2.(a) If veteran, name war... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1946 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 26, 1940, 18, to May 28, 1946.

and that I last saw him alive on May 28, 1946.

Immediate cause of death Cerebral hemorrhage or hemiplegia and causes unspecified. DURATION 4 days

Due to General Paresis

Unk.

Due to Generalized arteriosclerosis

Unk.

including brain.

Other conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results Arteriosclerosis (no other gross findings)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

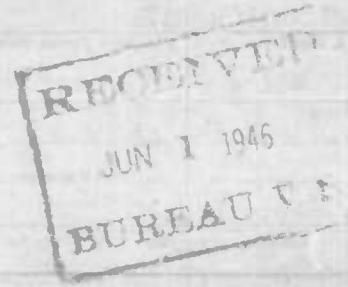
Injured at work?

23. SIGNATURE

Harry W. Ulmer, Jr.

M. D. or other

Address Sherppard-Pratt Hospital Date signed 5/29/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Bacon

Taylor Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

List Registered No. 38

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 8023 Dalesford Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)(d) Street No. 8023 Dalesford Road
(If rural give location)

(e) If foreign born, how long in U. S. A? years

3 (a) FULL NAME

Harry Calvin Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male 5. Color or race white

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife Mary Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1874

8. AGE: Years Months Days If less than one day
71 8 8 .hr. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

12. Name George Barnes

13. Birthplace ?

14. Maiden Name ? Smith

15. Birthplace ?

16 (a) Informant Mrs. Mary C. Barnes

(b) Address 8023 Dalesford Road

17 (a) Burial (b) Date thereof 5/9/46
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road

19 (a) 5/8/46 (b) G. W. Bacon
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th, 1946 at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946, to May 1946 and that I last saw him alive on May 6, 1946

Immediate cause of death

Hemiplegia, left Duration 22 days

Due to Hypertension
to toxic myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature G. W. Bacon M.D.

Address 1810 Taylor Ave. Date signed 5/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04545

Bla

Reg. Dist. No. 33

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....Baltimore
City or town.....Woodensburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....19 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Millie Ellsworth Barrick4. Sex.....Female 5. Color or race.....white 6. (a) Single, married, widowed, or divorced.....widowed6. (b) Name of husband.....Milton S. Barrick7. Birth date of deceased (mo., day, yr.).....12 June 1862 6. (c) If alive, give age.....years8. AGE: Years.....83 Months.....11 Days.....0 11 less than one day.....hrs.....min.9. Birthplace.....Baltimore City, Maryland
(Town, county, and state)10. Usual occupation.....Housewife

11. Industry or business

12. Name.....William S. Mabbett13. Birthplace.....Utica, New York14. Maiden name.....Margaret A. McCullom15. Birthplace.....Frederick County, Md.16. Informant.....Mrs. Kate I. Tracy, SisterAddress.....Riisterstown, Md.17. Burial.....Burial Date thereof.....May 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or.....Emory ChurchLocation.....near Finksburg18. Funeral director.....Wm. Brewster & SonAddress.....Riisterstown, md19. Date rec'd by registrar.....May 13 1946 Name of Registrar.....Daisy B. Eline

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Woodensburg County.....Baltimore

City or town.....(If outside city or town limits, write RURAL and give nearest town)

Street No.....(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

711-1

MEDICAL CERTIFICATION

20. DATE OF DEATH.....5-17-46 at9A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....1-1-35 19.....to.....5-13-46 19.....and that I last saw her.....alive on.....5-17-46 19.....

Immediate cause of death.....

Respiratory (Corna)

DURATION

3 dayDue to.....Hepatitis - ChronicDue to.....HypertensionOther conditions.....Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

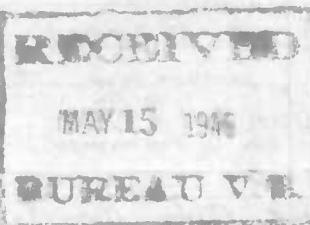
Means of injury.....

Injured at work?.....

23. SIGNATURE.....James G. Sappell

M. D. or other

Address.....Rustin Date signed.....5-13-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(BD)*

CERTIFICATE OF DEATH

04547 38
Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *Sept 28 1944*

Hospital, Institution, or street address where death occurred.

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? *Since Sept 28, 1944*

3. (a) FULL NAME

Amelia Maria Batis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

8. (b) Name of husband or wife *George D Batis*7. Birth date of deceased (mo., day, yr.) *June 10, 1901* 6. (c) If alive, give age years8. AGE: Years Months Days It less than one day
44 11 16 hrs. min.9. Birthplace *Austria*
(Town, county, and state)10. Usual occupation *Seamstress*11. Industry or business *Social Security No- 118-01-5915*12. Name *Audrey Tisuko*13. Birthplace *Austria*14. Maiden name *Catherine Madley*15. Birthplace *Austria*

Personal History- Hospital Records

16. Informant *Eudowood Sanatorium, Towson 4, Md.*Address *Eudowood Sanatorium, Towson 4, Md.*17. Burial Date thereof *May 29, 1944*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Moreland Memorial Park*Location *Baltimore, Md.*18. Funeral director *John Cook Son*Address *1917 St Paul St, Baltimore, Md.*19. Date record by registrar *5/27/44* 19. Registrar *W.A. Bridges*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Essex* (If outside city or town limits, write RURAL and give nearest town)Street No. *Baltimore Rd 16 (Zany St)* (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 26, 1944, 8:30 a.m.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept 26, 1944* to *May 26, 1944* and that I last saw her *alive on May 25, 1944*.

Immediate cause of death

Cause of death *Pulmonary tuberculosis* Duration *Since April 1944*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *W.A. Bridges* M. D. or otherAddress *Towson 4, Maryland* Date signed *5-26-44*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93A

04548

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

Baltimore
County: Cockeysville Md
City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Md

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Caroline C. Blackburn

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widower

6. (b) Name of husband or wife Arthur Blackburn

7. Birth date of deceased (mo., day, yr.)

Aug. 5, 1878

6. (c) If alive, give age

years

8. AGE: Years Months Days If less than one day

67 9 19 hrs. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

John Conrad Euler

12. Name John Conrad Euler

13. Birthplace Germany

14. Maiden name Caroline C. Haase

15. Birthplace Germany

16. Informant Laura M. Schroeder

Address Masonic Home, Cockeysville Md

17. Funeral Racial

Date thereof May 27, 49
(month) (day) (year)

Cemetery or crematory Oaklawn

Location Baltimore

18. Funeral director Wm. Cook

Address St. Paul & Preston St

19. May 24 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1207 S. North Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1946 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18 1946 to May 24 1946 and that I last saw her alive on May 24 1946

Immediate cause of death

Coronary Occlusion c

Thrombosis in Tractum

DURATION

6 days

Due to

Hypertension Cardis

Due to Vascular disease

3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

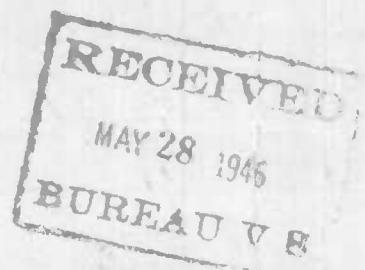
23. SIGNATURE

Walter J. Kees M.D. or other

Powers Apartments Date signed 5/24/46

Address 100 W. 36th St. New York City

PAGE CONTENT



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

64549

CERTIFICATE OF DEATH

Reg. Dist. No. 85-

1. PLACE OF DEATH:

County.....Baltimore
 City or town.....Rural near Parkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....42 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife	Nina May
-------------------------------	----------

7. Birth date of deceased (mo., day, yr.)	July 24, 1874.	63
---	----------------	----

8. AGE:	Years 71	Months 9	Days 19	If less than one day hrs. min.
---------	-------------	-------------	------------	--

9. Birthplace	Parkton, Md. P. D.
---------------	--------------------

(Town, county, and state)

10. Usual occupation	Machinist.
----------------------	------------

11. Industry or business	Paper mill.
--------------------------	-------------

12. Name	Valentine Bollinger.
----------	----------------------

13. Birthplace	Germany.
----------------	----------

14. Maiden name	Lydia Smith.
-----------------	--------------

15. Birthplace	Md.
----------------	-----

16. Informant	Mrs. Benjamin Cummings.
---------------	-------------------------

Address	Bentley Springs Md.
---------	---------------------

17. Burial	Date thereof..... <u>May 15 1946</u> <small>(Burial, cremation, or removal. Which?)</small>
------------	--

Cemetery or crematory	Mt. Zion
-----------------------	----------

Location	Freeland, Balto. C. Md.
----------	-------------------------

18. Funeral director	Jacob Hartenstein.
----------------------	--------------------

Address	New Freedom Pa.
---------	-----------------

19. Date rec'd by registrar	May 14 1946
-----------------------------	-------------

(Date received by registrar)	Lester L. Feller
------------------------------	------------------

Registrar	Debie Feller
-----------	--------------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Baltimore

City or town.....Rural near Parkton
(If outside city or town limits, write RURAL and give nearest town)

Street No.....Bentley Springs
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

216-10-1831

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 13, 1946, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 30 1941 to May 13 1946and that last saw him alive on May 10 1946.

Immediate cause of death.....

ArteriosclerosisCardio-vascular disease 6 yrs

Due to.....

Arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....Paul J. Hartenstein M. D. or otherAddress.....Oakhurst, Pa. Date signed.....May 18 1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-5

CERTIFICATE OF DEATH

04550
Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months, 17 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 11 months, 17 days

3. (a) FULL NAME

Frank Morrison Boyd

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife..... Ethel Scott

7. Birth date of deceased (mo., day, yr.) January 6, 1890

8. AGE:	Years	Months	Days	If less than one day
	56	4	11	hrs. min.

9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... Salesman

11. Industry or business..... Manufacturing companies

12. Name..... Clarence Boyd

13. Birthplace..... Maryland

14. Maiden name..... Virginia Royston

15. Birthplace..... Maryland

16. Informant..... Hospital records

Address..... Catonsville-28, Maryland

17. Burial..... Date thereof..... 5-20-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parkwood Cemetery

Location..... Baltimore, Maryland

19. Funeral director..... HENRY SANDER & SONS, INC.

Address..... NORTH AVE. & BROADWAY

18. (_____) 5/20/46 (_____) *Isadore Tuerk*
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore-13
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 2001 East Lafayette Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 17 1946 at 10:00 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 30 1945, to May 17 1946

and that I last saw him alive on May 17 1946

Immediate cause of death.....

General paresis

DURATION

Indefinit

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Doctor Tuerk

Isadore Tuerk, M.D.

23. SIGNATURE..... M. D. or other

Address..... Catonsville-28, Md. Date signed 5-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

P
Registered No. _____

1. PLACE OF DEATH: *Baltimore*
 (a) Baltimore City, Maryland
 (b) Street address *5501 Edmondson Ave*
 (c) Hospital or institution: *Good Samaritan Home*
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) *1 1/2*

2. USUAL RESIDENCE OF DECEASED: *Maryland*
 (a) State *Maryland* County _____
 (c) City or town *Baltimore*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *26 N. Monastery Ave.*
 (If rural give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country _____

3. (a) FULL NAME *JENA E. BREITENBACH*
 3. (b) If veteran, name war _____
 3. (c) Social Security Account No. _____
 4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*
 6. (b) Name of husband or wife *Louis H.*
 6. (c) If alive, give age *8* years
 7. Birth date of deceased (mo., day, yr.) *12-29-1875*
 8. AGE: Years *70* Months *4* Days *27* If less than one day _____ hr. _____ min.
 9. Birthplace *Baltimore, Md.*
 (Town, county, and state)
 10. Usual Occupation *Housewife*
 11. Industry or business *At Home*
 MOTHER FATHER
 12. Name *Lambert Teufel*
 13. Birthplace *Germany*
 14. Maiden Name *Nellie Kispert*
 15. Birthplace *Germany*
 16. (a) Informant *MRS. WM. H. Schwab*
 (b) Address *26 N. Monastery*
 17. (a) Burial place *Burial* (b) Date thereof *5/29/46*
 (Burial, cremation, or removal) (month) (day) (year)
 (c) Cemetery or crematory *Western*
 Location *Baltimore City*
 18. (a) Funeral director *J. D. Gilbert*
 (b) Address *1300 Euclid Place*
 19. (a) Date rec'd by registrar *5-29-46(b)*
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *25 May* 1946 at *11:30 P.M.*
 21. I certify that death occurred on the date above stated; that I attended deceased from *May 21* 1946 to *May 25* 1946, and that I last saw her alive on *May 22* 1946.

Immediate cause of death *CEREBRAL HEMORRHAGE* Duration _____

Due to *After stroke* CVD

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? _____ While at work? _____
 (Specify type of place)

(e) Means of injury _____

23. Signature *J. D. Gilbert*

Address *333 Frederick Ave* Date signed *5/28/46*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195-8

14552
32

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 yr.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

April 19, 1942

8. AGE:

Years	Months	Days	If less than one day
4	1	9	hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

Edward L. Brewster

12. Name

Take Forest Illinois

13. Birthplace

Kathleen Mallory

14. Maiden name

Baltimore, Maryland

15. Birthplace

Edward L. Brewster

16. Informant

Edward L. Brewster

Address

Pikesville, Maryland

17. Burial

Date thereof May 31-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mt. Olivet

Location

Frederick Rd. Baltimore

Date thereof May 31-46

(month) (day) (year)

(month) (day) (year)

(month) (day) (year)

18. Funeral director

Frank N. Howell

Address

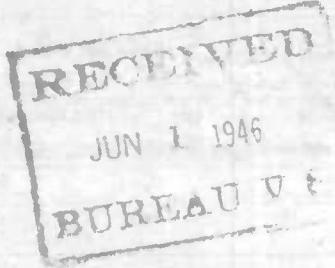
Pikesville, Maryland

19. (Date rec'd by registrar)

1946

Date signed

5-31-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1952)

04553

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Baltimore
City or town Pikeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr
Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Female white Married
Kathleen Mallory Brewster
Edward J. Brewster
6. (b) Name of husband or wife _____
6. (c) If alive, give age 32 years
7. Birth date of deceased (mo., day, yr.) May 20, 1914
8. AGE: Years 32 Months 8 Days 1 If less than one day _____ hrs. _____ min.
8. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Housewife

11. Industry or business John J. Mallory
Mother Father John J. Mallory
12. Name John J. Mallory
13. Birthplace Philadelphia, Pa.
14. Maiden name Minnie W. Colby
15. Birthplace Baltimore, Maryland
16. Informant Edward J. Brewster
Address Pikeville, Maryland

17. Burial Burial Date thereof May 31, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Olive
Location Fredrick Rd. Baltimore

18. Funeral director Frank H. Merrill
Address Pikeville, Maryland
19. 5-31-1946 (Date rec'd by registrar) Dr E E Nichols M.D.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Pikeville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Reinertown Road (If rural, give LOCATION) Kedar Rd.

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1946 at 7:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1946 to May 28 1946 and that I last saw her alive on May 28 1946.

Immediate cause of death Explosion in kitchen at home
Second degree burns of
Due to legs, abdomen & arms Duration Instant
2nd degree

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings or operations None Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

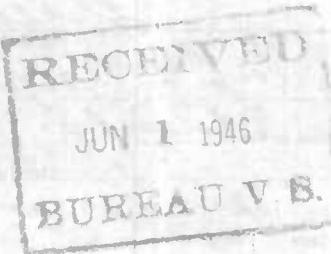
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-28-46
Where did injury occur? Pikeville, Baltimore, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Gas explosion Injured at work? No

23. SIGNATURE D. D. Copley, M.D. M.D. or other
Address Reisterstown, Md. Date signed 5-30-46



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-d

64554

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:

County

Baltimore Sunnysbrook Phoenix

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Ensor Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white widowed

6. (b) Name of husband or wife

Elizabeth R.

7. Birth date of

deceased (mo., day, yr.)

March 24, 1854

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

92

1.

8

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by Registrar

(Date rec'd by Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Baltimore

City or town

Sunnysbrook

Street No.

Phoenix P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 2 1946 at 11 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 10-1944 to May 2 1946
and that I last saw him alive on Apr. 30 1946

Immediate cause of death

Coronary thrombosis

DURATION

2 days

Due to

Myocarditis -
arterio sclerosis -

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

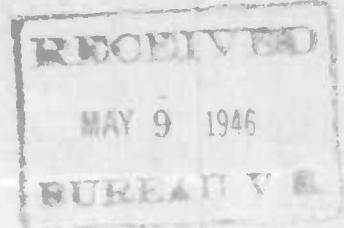
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cockeysville Md. Date signed 5/3/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Grott
8100 Harford Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

C4556

Reg. Dist. No. 38

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Parkville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8325 Harford Road

How long in hospital or institution?

3. (a) FULL NAME

Mary F. Buccheri

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife..... G.L. Buccheri

7. Birth date of deceased (mo., day, yr.) May 14, 1872
6. (c) If alive, give age years8. AGE: Years Months Days If less than one day
73 11 23 hrs. min.9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... at home

11. Industry or business

12. Name..... John Sindall

13. Birthplace..... Md.

14. Maiden name..... Margaret V. Tillet

15. Birthplace..... Md.

16. Informant..... Mr. G. L. Buccheri

Address..... 8325 Harford Road

17. Burial..... Date thereof..... 5/9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parkwood

Location..... Baltimore

18. Funeral director..... Leonard J. Ruck

Address..... 5305 Harford Road-14-

19. Date recd by registrar..... 1946 A.M. Bass
(Date recd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Parkville

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 8325 Harford Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 7th, 1946 et 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
9 am. 1 1945 to May 7, 1946,
and that I last saw her alive on May 6, 1946.

Immediate cause of death..... Acute pulmonary edema

Duration..... 1 day

Due to..... Hypertension Cardia -

Due to..... Muscular disease 2 yrs.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

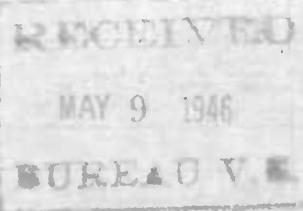
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Harold A. Grotz, M.D.
M. D. or other.....
Address..... 8100 Harford Rd. Date signed..... 5/18/46.



Dr. Bacon

MARYLAND STATE DEPARTMENT OF HEALTH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

clerk
Registered No. 38

44557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Co.
 (a) Baltimore City, Maryland
 (b) Street address..... #3000 Arizona Avenue
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md. (b) County Parkville
 (c) City or town Baltimore
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. 3000 Arizona Avenue
 (If rural give location)
 (e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Henry F. Buschman

3 (b) If veteran, name war	3 (c) Social Security Account No.
----------------------------	-----------------------------------

4. Sex <u>male</u>	5. Color or race <u>white</u>	6 (a) Single, married, widowed, or divorced. <u>widowed</u>
--------------------	-------------------------------	---

6 (b) Name of husband or wife Mary Ann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1 - 1866

8. AGE: Years 80 Months 3 Days 8 If less than one day
 hr. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
 12. Name ?

13. Birthplace ?

MOTHER
 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Estate of Henry Buschman
 (b) Address 3000 Arizona Avenue

17 (a) Burial Baltimore (b) Date thereof 5/11/46
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
 Location Baltimore

18 (a) Funeral director Leonard J. Ruck
 (b) Address 5305 Harford Rd.

19 (a) 5/10/46 (b) G. M. Bacon
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th, 1946, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935, to May 9 1946, and that I last saw him alive on May 9 1946.

Immediate cause of death

Tubercular myocarditis
Hypertension
 Due to arteriosclerosis

Duration
 10 years
 10 years
 10 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations.

Of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide.
- (b) Date of occurrence.
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? While at work?
 (Specify type of place)
- (e) Means of injury.

23. Signature G. M. Bacon
 M. D.
 Address 2850 Taylor Ave Date signed 7/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

1455

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County.....

Baltimore County

City or town.....

Ruxton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?....

40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William Cabell Bruce

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Louise Estelle Fisher Bruce

deceased

8.(c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

March 12th 1860

8. AGE:

Years

Months

Days

If less than one day

86

1

28

— hrs.

— min.

9. Birthplace

Charlotte County Va

(Town, county, and state)

10. Usual occupation

Lawyer, ex. U.S. Senator

11. Industry or business

Charles Bruce

12. Name

Charles Bruce

13. Birthplace

Halifax Co. Va

14. Maiden name

Sally Seddon

15. Birthplace

Fredericksburg Va

16. Informant

Wm A. Triplett

Address

715 Park Ave Baltimore Md

17. Burial

Date thereof May 11 1946

(Burial, cremation, or removal. Which?)

(month)

(day)

(year)

Cemetery or crematory

St. Thomas' Church

Location

Baltimore Md.

18. Funeral director

H.W. Jenkins & Sons Co. Inc.

Address

11 Culloch & Orchard Sts. Baltimore

19. Date rec'd by registrar

4-9-46

19. M. D. or other

Date signed

18 Eager St.

Date signed

May 9 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore County

City or town Ruxton

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 9

1946

at 9²⁰ a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2

1946

to

May 9

1946

and that I last saw him alive on May 8

1946

Immediate cause of death

Inflammation of the brain.

DURATION

6 mos.

Due to

Cardiac seizers, generalized convulsions.

Due to

Paroxysmal agitans.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

W. P. Mulligan

M. D. or other

Address

18 Eager St.

Date signed

May 9 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

evidence for the change of
year of birth shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

14558

FILM No. 106 JUL 17 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County

City or town

Baltimore

Pikesville

(If outside city or town limits, write RURAL and give nearest town)

45 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6(a) Single, married, widowed, or divorced

Male white married

8(b) Name of husband or wife

Mae Bushmiller

7. Birth date of deceased (mo., day, yr.)

Dec. 22. 1894 1893

8(c) If alive, give age 50 years

8. AGE: Years Months Days If less than one day

52 4 18 hrs. min.

9. Birthplace (Town, county, and state)

Baltimore City, Md

10. Usual occupation

Clerk

11. Industry or business

Baltimore County Md

12. Name

Henry Bushmiller

13. Birthplace

Germany

14. Maiden name

Elizabeth Buddie

15. Birthplace

Germany

16. Informant

Mae E. Bushmiller

Address

1102 Rustleton Rd. Pikesville

Burial

Date thereof May 14-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

New Cemetery

Location

Edmond & Franklin Rd.

18. Funeral director

Frank H. Nevel

Address

Pikesville Maryland

19. 5-13-1946

Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1102 Rustleton Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

me

3. (b) Social Security Number

218-03-5362

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1946 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5th 1946 to May 9th 1946 and that I last saw him alive on May 9 - 1946.

Immediate cause of death

Coronary Thrombosis 5 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

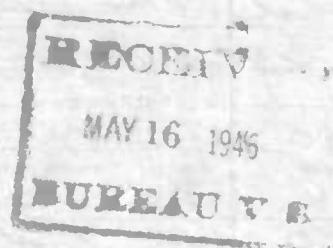
Means of injury

Injured at work?

23. SIGNATURE

E. E. Nichols, MD M. D. or other

Pikesville 87nd Date signed 5/13/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

64559

CERTIFICATE OF DEATH

Reg. Dist. No.

40

1. PLACE OF DEATH:

County.....

Baltimore
Takoma

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Julie C. Busick

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. M.

Married

B. (b) Name of husband or wife

Robert H. Busick

7. Birth date of deceased (mo., day, yr.)

Dec 25 - 1898

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Troy N.Y.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Timothy Dwyer

12. Name

MOTHER FATHER

13. Birthplace

Troy N.Y.

14. Maiden name

Catherine Cunningham

15. Birthplace

Ireland

16. Informant

Robert H. Busick

Address

Hyde Med.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

May 23 1946

E. E. Arthur

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Baltimore

City or town.....

Troy

Md.

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 22 1946 at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that deceased from

Cav. 8, 1944 to May 22, 1946

and that I last saw her alive on May 22, 1946

Immediate cause of death

Gastric carcinoma of L.
Meat w/ 86%
metastasis to spine, 3 yrs
Due to
Mediastinum and lung

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Advanced carcinoma

Date of op. 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

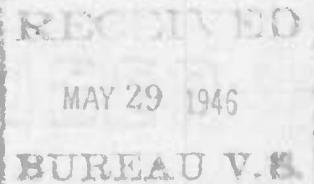
Injured at work?

Signature

M. D. or other

Address

Date signed 5/23/46



STATE OF MARYLAND—CERTIFICATE OF DEATH

4560

41

1. PLACE OF DEATH

County

Baltimore

HO

Registration Dist. No.

Village or City

Dundalk

Length of residence in city or town where death occurred

yrs.

No. 222 87 Helena Ave. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)
mos. 5 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

William Butz (BUTZ)

(a) Residence: No. 222 87 Helena Ave. St., Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Male White

Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

John V.

6. DATE OF BIRTH (month, day, and year)

May 24/1873

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

72 11 29

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)Machine Operator
Schmidt Bakery

12. BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

MOTHER FATHER

13. NAME

John George P. M. Butz

14. BIRTHPLACE (city or town)

(State or country)

Germany

15. MAIDEN NAME

Dorothy Matmon

16. BIRTHPLACE (city or town)

(State or country)

Germany

17. INFORMANT

(Address)

Mrs. Lillian M. Garrett
8-5518 Bosworth Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

, 19

Twin Park

5/25

19

19. UNDERTAKER

(Address)

William Butz Jr.

20. FILED

Date

, 19

5/25 1946

Our Husband

Registr.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY. That I attended deceased from

May 24/46 to May 22/46.

I last saw him alive on , 19 ; death is said

to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Coronary occlusion

Date of onset

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury , 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred IN INDUSTRY, IN HOME, or IN PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

McBarrowine

M. D.

Deputy Medical Examiner

Baltimore, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

P
04561

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County

Baltimore
(If outside city or town limits, write RURAL and give nearest town)

City or town Bowleys Quarters

How long in above place of death? Seven years

Hospital, institution, or street address where death occurred: at home

How long in hospital or institution? at home

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white Married John H. Calvert

6. (b) Name of husband or wife

John H. Calvert

6. (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) May 9 1911

8. AGE: Years Months Days If less than one day

34 11 27 hrs. min.

9. Birthplace Pennsylvania

(Town, county, and state)

10. Usual occupation House-wife

11. Industry or business

12. Name Walton M. Wentz

13. Birthplace Linelawn Md.

14. Maiden name Fannie Sowitz

15. Birthplace Spring Grove Pa.

16. Informant Edie Russell (Parabank)

Address Bowleys Quarters

17. Burial Date thereof May 9 1946

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Parkville-Balto

18. Funeral director Stevens Mortg Co.

Address 108 W. Park Ave. I

19. 5/8 1946 A.M. 1 P.M.

(Date rec'd by registrar) Registrar 3 m.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2.(a) If veteran, name war

Md Bally's Quarters

(If outside city or town limits, write RURAL and give nearest town)

Glenwoood Road

(If rural, give LOCATION)

(no)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1946, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1945, to May 6, 1946,

and that I last saw her alive on 19.

Immediate cause of death generalized malnutrition

DURATION

14-18

months

Due to generalized metastasis from carcinoma of the breast, right

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of breast, right

Date of op. July 9, 1945

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edie Russell, Jr., M.D. M. D. or other

Address 101 E. 13th St. Date signed 5/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04562
57

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County...
*Baltimore*City or town...
Texas

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?...
working place

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Wilbert Abraham Causon

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M**Colored married*8. (b) Name of husband or wife...
*Sarah Gardner*7. Birth date of
deceased (mo., day, yr.)

8. (c) If alive, give age

3.5

years

Jan 22, 1905

8. AGE:

Years

Months

Days

If less than one day

41

3

18

hrs.

min.

9. Birthplace

Sparks, Balt. Co. Md.

(Town, county, and state)

10. Usual occupation

laborer & janitor

11. Industry or business

Quarry

FATHER

12. Name

Clarence Bryan

MOTHER

13. Birthplace

Balt. Co. Md.

14. Maiden name

Sadie Causon

15. Birthplace

Sparks, Balt. Co. Md.

16. Informant

Sarah Gardner Causon

Address

112 E. Chesapeake Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

5 12 46

(month) (day) (year)

Cemetery or crematory

Stephenson Chapel

Location

Sparks, Md.

18. Funeral director

Faudon M. Brooks

Address

Sparks, Md.

19. Date rec'd by registrar

*May 11 46**Wilmer C. Ensor*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State...
*Md.*County...
*Baltimore*City or town...
Towson 4

(If outside city or town limits, write RURAL and give nearest town)

Street No.
112 E. Chesapeake

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

219-01-3999

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 9 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*19. to 19.*and that I last saw h. *alive*

Immediate cause of death

Bl. location

DURATION

*5/9/46*Due to *Accident. Fell into cement vault*

5/19/46

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. *Accident*, Date of *5/9/46*Where did injury occur? *Texas* (City or town) *Baltimore* (County) *Md.* (State)Injured at home, farm, industry, public place (where?) *Campbell's Garage - trunk*Means of injury *Fell in cement vault* Injured at work? *Yes*

23. SIGNATURE

Rollin G. Hudson M.D. D.M.E.

M. D. or other

Address *Towson Md.* Date signed *5/9/46*

RECEIVED TO DIRECTOR OF STATE GRANT PROGRAM
RECORDED IN INDEX

REC'D

MAY 14 1946

U.S. GOVERNMENT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04563
48

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since March 24, 1946

Hospit al, Institution, or street address where death occurred:

Endowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since March 24, 1946

3. (a) FULL NAME

Martha Chinn (Martha CHIN)

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Chinese Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

18 hrs. min.

9. Birthplace.....

Baltimore Md

(Town, county, and state)

10. Usual occupation.....

School girl

11. Industry or business

12. Name.....

Martha Chinn

13. Birthplace.....

Carrollton Ohio

14. Maiden name.....

Emma Leon

15. Birthplace.....

Maryland

Personal History- Hospital Records

16. Informant.....

Address.....

Endowood Sanatorium, Towson 4, Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof..... 25-30-46
(month) (day) (year)

Cemetery or crematory.....

Lorraine

Location.....

Woodlawn

18. Funeral director.....

Stewart Morris Co.

Address.....

108 W North Ave.

19. (Date rec'd by registrar)

5-29-46

20. (Date death registered)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore City

City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No..... 902 E. Franklin St (If rural, give LOCATION)

2.(c) If veteran, name war.....

MEDICAL CERTIFICATION

2d. DATE OF DEATH..... May 28 1946 at 8:05-9

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 24, 1946 to May 28 1946

and that I last saw her alive on May 27 1946

Immediate cause of death.....

Pulmonary tuberculosis

Due to..... Since April 1946

Due to..... April 1946

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... G.A. Bridgeman

M. D. or other

Address..... Towson 4, Maryland Date signed..... 5-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

P
Registered No. 14565

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address Edmondson Ave. & Nunnery Lane
 (c) Hospital or institution:
The Opitz Home
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County _____
 (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
 (d) Street No. 2312 Boston Street
(If rural give location)
 (e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME

JULIAN CHRZANOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

Bertha (Bronislawa)6 (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) May ? 1885

8. AGE: Years	Months	Days	If less than one day
<u>61</u>			hr. min.

9. Birthplace Chrzanow, Poland

(Town, county, and state)

10. Usual Occupation Proprietor11. Industry or business Tavern12. Name Peter Chrzanowski13. Birthplace Chrzanow, Poland14. Maiden Name Teofila Kolakowska15. Birthplace Chrzanow, Poland16 (a) Informant Mrs. Bertha Chrzanowski(b) Address 2312 Boston Street17 (a) Burial Burial (b) Date thereof 5/8/46
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory St. StanislausLocation Mt. Carmel Road18 (a) Funeral director M. J. Sadowski & Sons(b) Address 1808 Eastern Avenue19 (a) 5-7-46 (b) Anatoly P. Dobrowsky
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1946 at 10:00 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1945 to May 4 1946, and that I last saw h. alive on May 3 1946.

Immediate cause of death

myocardial insufficiencyoedema

Duration

3 days2 hrs.7 hrs.Due to left hemiplegia.

?

Due to hypertension, arterio-sclerosis.

?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____ at _____ M

(b) Date of occurrence _____ at _____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury Sabotage23. Signature R. C. DobrowskyAddress 447 U. Kenwood Av. Date signed 5/6/46 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

4565

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County.....

Balto.

City or town.....

Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 20 Years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

BESSIE SKUTCH CONE.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

8. (b) Name of husband Dr. Sydney M. Cone.

7. Birth date of deceased (mo., day, yr.) June 9th. 1880.

8. AGE: Years Months Days If less than one day
65 11 7 hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Max Skutch,
13. Birthplace Bavaria.14. Maiden name Fannie Frank,
15. Birthplace Balto. Md.16. Informant Mr. Maxwell Cone,
Address Woodholme Ave.17. Cremation Date thereof May 20th. 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or columbarium Loudon Park.

Location Balto. Md.

18. Funeral director David Sonnheim & Son
Address 1902 Eutaw Place.19. 5/18 1946 a.m. 11:45 a.m. Registrar
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Woodholme Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th. 1946, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1945 to May 16th 1946 and that I last saw her alive on May 16th 1946.

Immediate cause of death

Carcinomatosis about 15 mos.

Due to

Carcinoma of Stomach (Symptoms) alt 18 mos.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma - pyloric end of stomach, gastro-enterostomy Date of op. Feb. 26, 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis P. Hamburger

M.D. or other

Address 1207 Eutaw Place. Date signed May 17/46.

Balto. Md.

MAY 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

T 205.

04567

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

225 W. Joppa Road

How long in hospital or institution?

3. (a) FULL NAME

John Jerome Crogan

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleWhiteMarried

6.(b) Name of husband or wife

Gertude T. Crogan

7. Birth date of deceased (mo., day, yr.)

August 14, 1876

6.(c) If alive, give age

54

years

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Real Estate Broker

11. Industry or business

Self

MOTHER FATHER

12. Name

Luke T. Crogan

13. Birthplace

Washington, D.C.

14. Maiden name

Elizabeth Falvey

15. Birthplace

Balto. Co., Maryland

16. Informant

Mrs. Gertude T. Crogan

Address

225 W. Joppa Rd., Towson 4, Md.

17. Burial

Date thereof May 21, 1946
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

New Cathedral Cem.

Location

Baltimore, Maryland

18. Funeral director

John Burns Sons

Address

Towson, Maryland

19. (Date rec'd by registrar)

May 20 1946
Reported by John Burns Sons

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 225 W. Joppa Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 18,

1946

a.m.

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 1 -

1946, to

May 18, 1946.

and that I last saw h.s.m. alive on

May 18

1946.

Immediate cause of death

Coronary Thrombosis

DURATION

1 day

Due to

Atherosclerosis

2 or 3 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

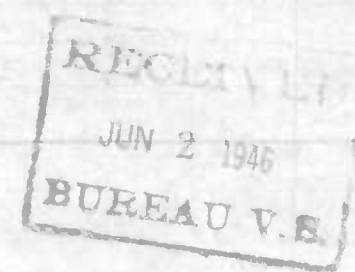
Injured at work?

23. SIGNATURE

R. Murray Fisher

M. D. or other

Address 18 E. Eager St. Date signed May 1946Balto.



Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased & birth date of deceased 2411 N. Charles St., Baltimore 836
is shown on
FILM No. I 04 MAY 16 1946

CERTIFICATE OF DEATH

04568

Reg. Dist. No. XX

P

1. PLACE OF DEATH:

County

Baltimore

City or town 717 F. STREET SPARRROWS PT. MD

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

Benjamin Thomas

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD

County

Baltimore

City or town SPARRROWS PT.

Ward No.

Street No. 717 F. ST.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

4. Sex M

5. Color or race W

6.(a) Single, married, widowed, or divorced

WIDOWED

6(b) Name of husband or wife NANIE VIRGINIA DAILEY

1865

years

7. Birth date of deceased (mo., day, yr.)

MAY 25 1865

1865

8. AGE: Years Months Days If less than one day

78 79 11 15 hrs. min.

9. Birthplace GLENCOE, MARYLAND

(Town, county, and state)

10. Usual occupation RECEIVING CLERK

11. Industry or business BETHLEHEM STEEL CO.

12. Name SETH DAILEY

13. Birthplace BALTIMORE Co.

14. Maiden name DAIVISON

15. Birthplace BALTIMORE Co

16. Informant MARGARET DAILEY

Address 717 F. ST. SPARRROWS PT.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof MAY 13, 1946

(month) (day) (year)

Cemetery or crematory EMMANUEL EPISCOPAL CEM.

Location GLENCOE, MD

18. Funeral director JOHN F. DENNY, INC

Address 715 LIGHT ST.

19. 5/11 1946

(Date rec'd by registrar)

A.W. Hedgpeth
Registrar
S.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 1946 to May 10 1946,
and that I last saw him alive on May 10 1946.

Immediate cause of death

Cerebral Thrombosis

DURATION

30 days

Due to Arteriosclerosis generalized

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Denny, M.D.

M. D. or other

Address 520 J St. Sp. Pt. Date signed 5/10/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-A

04569 R

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
Baltimore
County.....
City or town..... Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 107 days
Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital
How long in hospital or institution? 107 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... *Mesomaria*
City or town..... Fruitland
(If outside city or town limits, write RURAL and give nearest town)
Street No..... Box 113
(If rural, give LOCATION)
2.(a) If veteran, name war..... World War II

3. (a) FULL NAME
MATTHEW S. DASHIELL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife..... Single

7. Birth date of deceased (mo., day, yr.) 10/3/14
6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
31 7 20 hrs. min.

9. Birthplace..... Fruitland, Md.
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business
MOTHER FATHER Solomon Dashiell (deceased)

13. Birthplace..... Maryland

14. Maiden name..... Alice Humphries

15. Birthplace..... Maryland

18. Informant..... Clinical Records

Address..... Vet. Hosp. Ft. Howard, Md.

17. Burial Date thereof: May 29-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Calvary

Location..... Highland Park, Md.

18. Funeral director..... James A. Stewart

Address..... Mt. Calvary, Md.

19. Date rec'd by registrar..... 5/27/46 A.W. Redick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 24 19 46 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6 19 46 to May 24 19 46 and that I last saw him alive on May 24 19 46

Immediate cause of death..... BRAIN TUMOR ; unqualified.
DURATION 2 Mos.

Due to..... Could not be determined whether he was malignant or malignant tumor.
Due to.....

Other conditions..... Syphilitic Chroiditis 2 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations..... Craniotomy

Date of op..... 5-23-46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Open
23. SIGNATURE..... Robert M. Cullison
R.M. CULLISON, M.D. CLIN. M.P. other

Address..... Ft. Howard, Md. Date signed..... 5-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1703

C4570

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH

County

Sparrow Pt Rd - Edgemere
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George F DeArment

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Mary Ellen

Mr. Cober

6.(c) If alive, give age

41

years

7. Birth date of deceased (mo., day, yr.)

April 13 - 1904

8. AGE:

42

Years

Months

Days

11 less than one day

hrs.

min.

9. Birthplace

Portage Pa.

(Town, county, and state)

10. Usual occupation

Night Shift.

11. Industry or business

Rheem Manufacturing Co.

12. Name

James DeArment

13. Birthplace

Pa.

14. Maiden name

Unknown

15. Birthplace

Pa.

16. Informant

James DeArment

Address

2812 Wells Ave.

17. Burial

Date thereof May 22 - 46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

German Stell Rd.

18. Funeral director

John G. Connally

Address

418 Eastern Ave. Essex

19. Date rec'd by registrar

May 21 1946 John G. Connally

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore.

City or town

Edgemere - 19

Street No.

2812 Wells Ave

(If rural, give LOCATION)

2.(a) If veteran, name war..

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

5-18-46

19..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h.....alive on.....

19.....

Immediate cause of death

Fractured skull

Bi-lateral fractures

Due to Auto accident

DURATION

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

5-18-46

Where did injury occur

Edgemere

Boro

Md.

Injured at home, farm, industry, public place (where?)

Public

Co.

Pub Co

Means of injury

Struck head w/

inj

Injured at work?

23. SIGNATURE

M. G. Davis M.D.

Dept. Med. Examiner State Co.

Address

Grindale 24 Date signed 5-18-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100

CERTIFICATE OF DEATH

★ (4571) Reg. Diat. No.

1. PLACE OF DEATH:
 County Baltimore
 City or town Kingsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAMERaymond P. Dilworth**3. (b) Social Security Number**

4. Sex <u>M.</u>	5. Color or race <u>W.</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
------------------	----------------------------	--

6.(b) Name of husband or wife <u>Mabel C. Dilworth</u>
--

7. Birth date of deceased (mo., day, yr.) <u>June 9 - 1898</u>	6.(c) If alive, give age <u>years</u>
--	---------------------------------------

8. AGE: Years <u>47</u>	Months <u>11</u>	Days	If less than one day
-------------------------	------------------	------	----------------------

..... hrs. min.

9. Birthplace <u>Md.</u>	(Town, county, and state)
--------------------------	---------------------------

10. Usual occupation <u>Contractor</u>
--

11. Industry or business <u>Howard C. Dilworth Due</u>
--

12. Name <u>Howard C. Dilworth</u>

13. Birthplace <u>Md.</u>

14. Maiden name <u>Ida Barnes</u>

15. Birthplace <u>Md.</u>

16. Informant <u>Mabel C. Dilworth</u>
--

Address <u>Kingsville Md.</u>

17. Burial <u>Burial</u>	Date thereof <u>May 9 - 1946</u>
--------------------------	----------------------------------

(Burial, cremation, or removal. Which?) <u>Cemetery or crematory</u>	(month) <u>Fork M. E. Cem.</u>	(day) <u>5</u>	(year) <u>46</u>
--	--------------------------------	----------------	------------------

Location <u>Fork Md.</u>

18. Funeral director <u>Clarence E. Arthur</u>
--

Address <u>Fork Md.</u>

19. Date rec'd by registrar <u>May 8 1946</u>	<u>G. E. Arthur</u>
---	---------------------

Registrar
D. T.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State <u>Md.</u>	County <u>Baltimore</u>
------------------	-------------------------

City or town <u>Kingsville</u>	(If outside city or town limits, write RURAL and give nearest town)
--------------------------------	---

Street No.	(If rural, give LOCATION)
------------	---------------------------

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1946 at 6:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1943 to May 6 1946 and that I last saw him alive on May 6 1946.Immediate cause of death Coronary Thrombosis 15 minDue to Half full with Captagon
and Infection of rectum
leptos & abdominal with
circus to propagationOther conditions Coronary Atherosclerosis 2 yrs.

Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

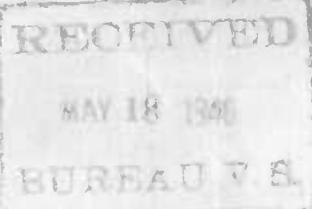
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson

M. D. or other

Address Zork Md. Date signed 5/8/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

4572

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Unknown

12. Name

13. Birthplace

"

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Francis J. Crewe

Address

Burd

Date thereof (month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Fork M. E.

Location

Fork Md.

18. Funeral director

Address

Clarence E. Arthur

Fork Md

19. May 23, 1976

(Date rec'd by registrar)

E. E. Arthur

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

March 10, 1946, May 20, 1946, at 8:45 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 1946, to May 20, 1946,

and that I last saw him alive on May 15, 1946.

Immediate cause of death

Congestive Heart Failure with decomp - 3 mos

Due to

Hypertensive Cardiovascular Disease

Due to

Hypertensive Cardiovascular Disease

Duration

3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

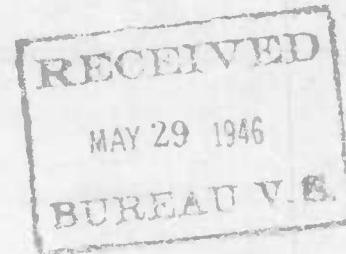
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D.

M. D. or other

Address Fork Md Date signed 5/23/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 140

04573

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County.....

City or town.....

*Baltimore**Fellerton P.L. Forge Rd.*How long in above place of death?.....*53 years*

Hospital, institution, or street address where death occurred:

Forge Road & Cross Road

How long in hospital or institution?

3. (a) FULL NAME

Louise Faustine Dorgbacher

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Female**white**single*

6.(b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

B. (c) If alive, give age..... years

July 15, 1878

8. AGE:

Years

Months

Days

If less than one day

67

10

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Germany

10. Usual occupation.....

At Home

11. Industry or business

FATHER

12. Name.....

John Dorgbacher

MOTHER

13. Birthplace

Germany

14. Maiden name

Julia Faustine

15. Birthplace

Germany

16. Informant

Mrs. Anna Butt

Address

Forge Rd. & Cross Rd. Fellerton Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

May 31, 1946

Cemetery or crematory

Jerusalem Lutheran

Location

Baltimore Md.

18. Funeral director

Josephine Funeral Home

Address

7401 Belair Road

19. Date rec'd by registrar

5/28/46

19.

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

May 27 1946 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on

Immediate cause of death.....

Strangulation by hanging Suicide

Due to.....

Depression

Due to.....

Atherosclerosis & hypertension

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

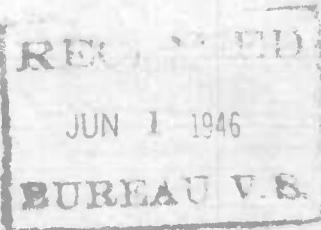
Wounded at work?.....

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

B.C

P

CERTIFICATE OF DEATH

64574
Reg. Dist. No. 4X

1. PLACE OF DEATH:
County..... Baltimore
City or town..... Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Maryland

How long in hospital or institution?..... 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 3608 Clifton Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war..... WW-I

3.(a) FULL NAME

WILLIAM KIRK DOUGHERTY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife..... Single

7. Birth date of deceased (mo., day, yr.)..... 2-17-1888

8. AGE: Years Months Days If less than one day
58 2 26 hrs. min.

9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... Unemployed

11. Industry or business

12. Name..... Richard A. Dougherty

13. Birthplace..... Maryland

MOTHER FATHER

14. Maiden name..... Arinthia Byrd

15. Birthplace..... Maryland

16. Informant..... Clinical Records, Vets. Adm. Hosp.
Address..... Fort Howard, Maryland

17. Burial..... Cremation Date thereof..... 5-16-46
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Greenlawn Cemetery

Location..... Wards Mill Road

18. Funeral director..... Odd Funeral Home Inc.

Address..... 4644 York Rd H-12

19. (Date rec'd by registrar)..... 11-11-46

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13, 1946, at 4:50 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
May 7, 1946, to May 13, 1946

and that I last saw h. i. m. alive on May 13, 1946

Immediate cause of death

Heart Disease, Coronary
Arteriosclerosis, cardiac enlarge-
ment, myocardial insufficiency

DURATION
Unknown

Due to

Other conditions..... Bronchopneumonia

Bronchitis chronic (From Records)
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

S.S. Robert M. Cullison
23. SIGNATURE..... R.M. CULLISON, M.D. CLIN. DIR.

Address..... Ft. Howard, Md. Date signed..... 5-13-46

Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B.C.

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 yrs., 10 mos., 14 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 29 yrs., 10 mos., 14 days

3. (a) FULL NAME

George Eggling

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

widowed

6.(b) Name of husband or wife.....

?

7. Birth date of deceased (mo., day, yr.)

December 16, 1869

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76

5

10

hrs.

min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

Brass moulder

11. Industry or business

Brass

MOTHER FATHER

12. Name.....

George Eggling

13. Birthplace.....

Maryland

14. Maiden name.....

Mary McEntee

15. Birthplace.....

Ireland

16. Informant.....

Hospital records

Address

Catonsville-28, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof.....

May 29/46

(month)

(day)

(year)

Cemetery or crematory.....

New Cathedral

Location.....

3800 Old Frederick Rd

18. Funeral director.....

Harry A. Wetke

Address.....

410 Edmondson St.

19. (Registrar)

S/25 46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

125 Scott Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 26

1946, at 4:55 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12

1946, to May 26, 1946.

and that I last saw h.....alive on.....

Immediate cause of death.....

Acute exacerbation

19.

DURATION

24 hours

Due to..... Chronic myocarditis

indef.

Due to..... Old pulmonary tuberculosis

of left apex

"

Other conditions..... Anæmia, extensive of un-
determined origin

"

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

Signature..... Isadore Tuerk, M.D.

M. D. or other

Address..... Catonsville-28, Md.

Date signed..... 5-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

04575 P

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County.....

Baltimore
Brooklandville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

35 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Anne Preston Emerson

3. (b) Social Security Number

4. Sex

F.

5. Color or race

Fr.

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Isaac Emerson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 28 1872

8. AGE:

Years
74Months
3Days
7

It less than one day

hrs. min.

9. Birthplace

New York City

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Wm. R. Preston

12. Name

Camden N.Y.

13. Birthplace

Rebecca Blyncamp

14. Maiden name

Eransville Ind.

15. Birthplace

Frederick McCormack

16. Informant

Stevenson Balt. & Md.

Address

Burke

Date thereof May 7, 1946
(month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Green Mount

Location

Balt. Md.

18. Funeral director

Henry W. Jackson & Sons Co.

Address

McCulloch & Edwards

19. S/6

1946 A.W. Hedrick

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Balt.

City or town.....

Brooklandville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 5 1946 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1945 to May 5 1946

and that I last saw her alive on May 3 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to

Stroke - Seizure or incident

to her age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter A. Baugh

M. D. or other

Address 1115 55 Paul St Date signed 5/1/46

57 Baileys
1115-11 Paul St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

14577

42

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 days

Hospital, institution, or street address where death occurred:

1823 Clark Blvd.

How long in hospital or institution?

3. (a) FULL NAME

Johanna Etchberger

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widowed

B. (b) Name of husband or wife

Ray Scott Etchberger

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 2 - 1885

Years Months Days If less than one day

61 2 0 hrs. min.

8. AGE:

9. Birthplace

(Town, county, and state)

Baltimore City

10. Usual occupation

Sales of women

11. Industry or business

Theatre cleaner

12. Name

Henry Thomas

13. Birthplace

Baltimore

14. Maiden name

Bertha Farmer

15. Birthplace

Baltimore

16. Informant

Mrs. R. F. Etchberger

Address 1823 Clarke, Relay Md

17. Burial

Date thereof 5/6/46

(Burial, cremation, or removal, which)

(month) (day) (year)

Cemetery or crematory

Balto

Location " Md.

18. Funeral director

William Cook Inc.

Address 1217 St. Paul St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B-5*

04578

38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Sept 30, 1935

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since Sept 30, 1935

3. (a) FULL NAME

FUNK, ANNIE MARTHA

3. (b) Social Security Number

4. Sex

F

5. Color or race

W WIDOWED

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Vernon Clark Funk

7. Birth date of deceased (mo., day, yr.)

JUNE 17, 1892

8. (c) If alive, give age years

8. AGE:

Years
53Months
10Days
23If less than one day
hrs. min.

9. Birthplace

(Town, county, and state)
Maryland

10. Usual occupation

Housewife

11. Industry or business

own Home

12. Name

Thomas Parks

13. Birthplace

Maryland

14. Maiden name

Emily Ennis

15. Birthplace

Maryland

Personal History- Hospital Records

16. Informant

Eudowood Sanatorium, Towson 4, Md.

Address

Eudowood Sanatorium, Towson 4, Md.

17. Burial

Burial

(Burial, cremation, or removal. Which?)

5/13/46

(month) (day) (year)

Cemetery or crematory

Moreland Park

Location

Parkville Md.

18. Funeral director

William Cook Inc

Address

217 St. Paul St.19. 5/1319. 4619. A-W. Hedrick

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County *oc*City or town Baltimore City (If outside city or town limits, write RURAL and give nearest town)Street No. 318 - South Wolfe St. (If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10

1946, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 30 1935, to May 10 1946and that I last saw her alive on May 10 1946

Immediate cause of death

Pulmonary tuberculosis

DURATION

Since

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W.A. Buddus

M. D. or other

Address Towson 4, Maryland Date signed 5-10-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

J. Registered No. 14564

1. PLACE OF DEATH:

(a) Baltimore, Maryland

(b) Street address Bare Hills, Falls Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME

3 (b) If veteran, name war

Sex Male

5. Color or race Colored

3 (c) Social Security Account No. None

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1867

8. AGE: Years Months Days If less than one day
78 9 24 hr. min.9. Birthplace Sandy Spring, Md.
(Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business

12. Name Samuel Gardman

13. Birthplace Howard Co., Md.

14. Maiden Name Julia Strong

15. Birthplace Montgomery Co., Md.

16 (a) Informant Mrs. Hattie C. Gardman

(b) Address Bare Hill, Falls Rd.

17 (a) Burial (b) Date thereof May 30, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Johns

Location Custon, Md.

18 (a) Funeral director Mrs. George A. Holland

(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar)

VS 150

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)(d) Street No. Bare Hill, Falls Rd.
(If rural give location)

(e) Citizen of foreign country? If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20, 1946, to May 27, 1946, and that I last saw him alive on May 27, 1946.

Immediate cause of death

Cerebral Hemorrhage

Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Louis A. Johnson M.D.

Address 2529 Greeff St. Date signed May 30, 1946

X

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

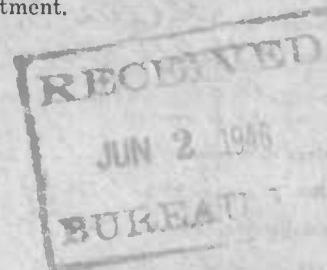
cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04579

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JULIA P. GATTON.

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Walter H. Gatton.

7. Birth date of deceased (mo., day, yr.)

March - 3rd. 1888

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day
58 2 28 hrs. min.

9. Birthplace

St. Mary's Co. - Md.

(Town, county, and state)

10. Usual occupation

House Work -

11. Industry or business

- At home

12. Name

Frederick Magill

Md.

13. Birthplace

Amanda Goldsborough.

Md.

14. Maiden name

Mrs. Linda Legore.

15. Birthplace

1815 Maxwell Ave

Address

Burial Date thereof June - 3-1946

16. Cemetery or crematory

Meadow Ridge Cemetery

Location

Charles J. Schupp.

17. Funeral director

505 N. Monroe St.

Address

613 XC

Date rec'd by registrar

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Lundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1815 Maxwell Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

5-31-

1946 at VP

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-27 1945 to 5-31 1946

and that I last saw her alive on 5-31-

Immediate cause of death

myocardial degeneration

DURATION

3 weeks

Due to

Carcinoma of the bladder.

2 years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

David Miller M.D.

M. D. or other

Address 1500 N. Broadway Date signed 6/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 116a

CERTIFICATE OF DEATH

PC
04580
P

Reg. Dist. No. 30

1. PLACE OF DEATH:

Baltimore
County.....
City or town.....Catonsville.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Days

Hospital, Institution or street address where death occurred:
Kennedy an

How long in hospital or institution?

3. (a) FULL NAME

M. Katherine Gibson

4. Sex Female | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) July 28, 1862

8. AGE: Years 83 | Months 9 | Days 26 | It less than one day hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Retired School Teacher

11. Industry or business..... Baltimore City

Joseph Gibson

12. Name.....

13. Birthplace..... Ireland

14. Maiden name..... Margaret Fusselbaugh

15. Birthplace..... Md.

16. Informant..... Mrs. Agnes H. Gibson

Address..... 2925 Winchester St.,

17. Burial..... Burial Date thereof..... 5-27-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Baltimore

Location..... Baltimore, Md.

18. Funeral director..... J. Howard Strong

Address..... 3207 W. North Ave.,

19. 5/27/46 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md.

County.....

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 2925 Winchester St.,

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 24, 1946, at 2:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

DURATION

*Acute cerebral failure*Due to *Cerebral vascular disease*Due to *accident pasted by*

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Homicide* Date of *May 10, 46*Where did injury occur? (City or town) *Baltimore City* (County) *Md.* (State) *No*Injury at home, farm, industry, public place (where?) *Home*Means of injury *Fallen down stairs* Injured at work? *No*23. SIGNATURE *J. Howard Strong* M. D. or other *Surgeon*Address *1010 Ledgard* Date signed *5/27/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death cleanly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

C4581

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
 County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 Years
 Hospital, Institution, or street address where death occurred: 9 Bishop's Lane
 How long in hospital or institution? -----

3. (a) FULL NAME

Christine Elizabeth Graber

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 Peter S. Graber

6.(b) Name of husband or wife Peter S. Graber
 7. Birth date of deceased (mo., day, yr.) December 24, 1865
 6.(c) If alive, give age ----- years

8. AGE: Years Months Days If less than one day
 80 5 5 ----- hrs. ----- min.

9. Birthplace Frederick, Md.
 (Town, county, and state)

10. Usual occupation None

11. Industry or business -----
 FATHER Peter Haydock

MOTHER 12. Name Austria
 13. Birthplace -----

14. Maiden name Miller
 15. Birthplace Germany

16. Informant Rosina E. Graber
 Address 9 Bishop's Lane, Catonsville

17. Burial Date thereof 6/1/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral
 Location Baltimore, Md.

18. Funeral director H. W. Mears and Son
 Address 805 N. Calvert Street

19. 6-1 Date rec'd by registrar 1946
 Harry L. Miller
 Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baltimore Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 9 Bishop's Lane
 (If rural, give LOCATION) -----

2.(a) If veteran, name war -----

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 29 May 1946 et 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 May 1946 to 29 May 1946 and that I last saw her alive on 29 May 1946.

Immediate cause of death ventricular failure DURATION 1 HR

Due to Chronic myocarditis UNKNOWN

Due to Atherosclerosis UNKNOWN

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of

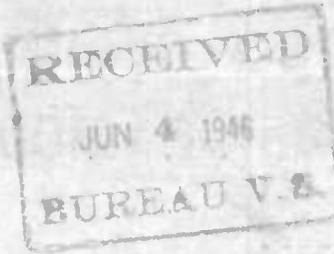
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stephen Leo Maguire MD M. D. or other

Address 752 Frederick Ave Date signed 31 May



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
 & birth date of deceased is shown 2411 N. Charles St., Baltimore 83-0
 on FILM No. I 04 MAY 22 1946 CERTIFICATE OF DEATH

64582
 Reg. Dist. No. 35

1. PLACE OF DEATH: Baltimore
 County: Towson
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred: 610 York Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Baltimore
 City or town: Towson (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 610 York Rd. (If rural, give LOCATION)

3. (a) FULL NAME

Henry Milton Gray

3. (b) Social Security Number

214-24-3767

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mabel Clare Gray
 7. Birth date of deceased (mo., day, yr.) Jan. 3, 1892 8.(c) If alive, give age 50 years
 8. AGE: Years 54 Months 55 Days 4 If less than one day 17 hrs. - min.
 9. Birthplace Baltimore Co., Maryland
 (Town, county, and state)
 10. Usual occupation Maintenance Man
 11. Industry or business Black & Decker Mfg. Co.
 12. Name Robert Henry Gray
 13. Birthplace Virginia
 14. Maiden name Harriett B. Dudson
 15. Birthplace Ohio

16. Informant Mrs. H. Milton Gray
 Address 610 York Rd., Towson, Md.
 17. Burial Date thereof May 23, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Loudon Park Cem.
 Location Baltimore, Md.
 18. Funeral director John Bunn's Sons
 Address Towson, Md.
 19. (Date rec'd by registrar) 5/21 '46 (Signature) John Bunn's Sons
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1946 at 3:45 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18.38 to 20 May 1946
 and that I last saw h.w.m. alive on 19 May 1946

Immediate cause of death Cerebral Hemorrhage

DURATION

6 hrs.

Due to Hypertension

BYRS.

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert H. Allison M.D.
 M. D. or other
 Address 4 Burkleigh Sq., Towson, Md. Date signed 20 May 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

64583

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Balto

Catonsville

How long in above place of death?

4 yrs 6 mos

Hospital, institution, or street address where death occurred

Spring Grove State Hosp

How long in hospital or institution?

4 yrs 6 mos

3. (a) FULL NAME

Christine Green

4. Sex

7 W

5. Color or race

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

George Green

7. Birth date of deceased (mo., day, yr.)

Oct. 24, 1864

6.(c) If alive, give age years

8. AGE:

Years Months Days If less than one day
81 6 9 hrs. min.

9. Birthplace.....

Baltimore

(Town, county, and state)

10. Usual occupation.....

unemployed

11. Industry or business

House wife

12. Name.....

Adam Hildesheim

13. Birthplace.....

Germany

14. Maiden name.....

Anna Hoffmeyer

15. Birthplace.....

Germany

16. Informant.....

Address

Hospital record

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month day year)
May 6/46

Cemetery or crematory.....

W. learned

Location.....

Balto MD

18. Funeral director.....

Philip Howard Jr.

Address

2924 Colgate St

19. (To be read by registrar)

J. S. C. Cardell

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

2304 Aiken St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 6 1946 at 19

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h. alive on 19

Immediate cause of death.....

Bronch Pneumonia

Due to.....

fractured left hip

Due to.....

sudden death

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.....

accident Date of April 23 46

Where did injury occur?.....

Catonsville Baltimore County State

Injured at home, farm, industry, public place (where?) Hospital

pushed from back bench by a boy of the patient no

Keens of Injury

hit him at work

23. SIGNATURE.....

Dr. Mr. Kieffer Egan Ball M. D. or other

Address.....

1010 Leed's Ave Date signed 5-3-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

04584

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County... Baltimore

City or town... Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 5 yrs. 1 mo., 16 days

Hospital, institution, or street address where death occurred: Mt. Wilson

Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 5 yrs., 1 mo., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County...

City or town... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No... 3600 White Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Mr. Marion Grimes

3. (b) Social Security Number

Unknown

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife... Mrs. Mable R. Grimes

7. Birth date of deceased (mo., day, yr.) September 2, 1889

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

56

8

3

hrs.

min.

9. Birthplace... Baltimore, Maryland

(Town, county, and state)

10. Usual occupation...

Chauffeur

11. Industry or business

12. Name... Louis N. Grimes

13. Birthplace Patapsco, Maryland

14. Maiden name Laurabelle Simmons

15. Birthplace Baltimore, Maryland

16. Informant... Mr. Marion Grimes

Address 3600 White Ave., Balto., Md.

17. Burial

Date thereof May 8, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Glen Haven Cemetery

Location Anne Arundel Co., Maryland

18. Funeral director... William Cook, Inc.

Address 1217 St. Paul St., Balto., Md.

19. May 5, 1946 Earl Webster

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5,

1946 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1941 to May 5, 1946, and that I last saw him alive on May 5, 1946.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

9 yrs.

Due to... Tubercle Bacilli

Due to...

Other conditions Oil Pneumonia

1 Wk.

(Include pregnancy within 3 months of death)

Major findings or operations... No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Stewart A. Shaffer M.D.

D. or other Address... Mount Wilson, Md.

Date signed 5/5/46

Reed - 5-8-46 Dr E E Nichols



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32
2698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Baltimore co.

City or town

Pikesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Scotts Laurel & Miford Rd

Stay in hospital or Inst. (yrs., or mos., or days)

45 yrs

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

John Wendell Grinage

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

colored

Married

6 (b) Name of husband or wife

Mrs Lourena Grinage

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.)

March 28 1893

8. AGE:

Years
53

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

School teacher

11. Industry or business

Baltimore Public School No. 117

MOTHER FATHER

John F. Grinage

13. Birthplace

Maryland

14. Maiden name

Miss Ruth Thomas

15. Birthplace

Maryland

16. Informant

Mrs Lourena Grinage

Address

Pikesville md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 29 1946
(month) (day) (year)

Cemetery or crematory

Mt. Auburn

Location

Baltimore, Maryland

18. Funeral director

Mrs. George W. Holland

Address

16131 Duck Hill Ave.

19.

(Date rec'd by registrar)

5/29/46

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore Co.

City or town

Pikesville and Ward No.

Street No.

Scotts Laurel & Miford Rd

(If rural give LOCATION)

2(e) IF VETERAN, NAME WAR

none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 - 25 1946, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 - 1 - 1946 to 5 - 25 1946,

and that I last saw him alive on 5/1/46 1946

Immediate cause of death

Myocarditis

DURATION

2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank A. Saunders MD

M. D. or other

Address 1029 N. Stricker St. Date signed 5-26-46

~~PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.~~

Md. State Dept. of Health
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1952

Registered No. 32

1. PLACE OF DEATH:
 (a) Baltimore City, Maryland
 (b) Street address: Pipersville, Md.
 (c) Hospital or institution: Newell's Funeral Home
- (d) Length of stay in hospital or inst. (yrs., mos., or days).
 (e) Length of stay in Baltimore (yrs., mos., or days).

2. USUAL RESIDENCE OF DECEASED:

- (a) State: Md. (b) County: Balt. City or town: Deer Park
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. (If rural give location)
 (e) Citizen of foreign country? Yes (Yes or No)
 If yes, name country.

3 (a) FULL NAME

Gay Campbell Griswold

- 3 (b) If veteran, name war
 3 (c) Social Security Account No.

4. Sex: Male 5. Color or race: White 6 (a) Single, married, widowed, or divorced.

- 6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1882

8. AGE: Years: 63 Months: 5 Days: 2 If less than one day hr. min.

9. Birthplace: Deer Park, Md. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

12. Name: Leni Griswold

13. Birthplace: Deer Park, Md.

14. Maiden Name: Florence V. Triplett

15. Birthplace: Deer Park, Md.

- 16 (a) Informant: Mrs. John Penny

- (b) Address: Deer Park

- 17 (a) Burial (b) Date thereof May 29-46
 (Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory: Deer Park

- Location: Deer Park, Md.

- 18 (a) Funeral director: Mr. Berryman & Sons

- (b) Address: Reisterstown, Md.

- 19 (a) 5/28/46 (b) Dr. E. E. Nichols
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1946 at 8 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Internal hemorrhage
Lacerated lungs

Due to: Accident undetermined cause

Other Conditions: Fractured ribs,
Lacerations and bruised

(Include pregnancy within 3 months of death)

22. If an external cause was primary or contributing cause of death, fill in the following:

(a) Date of injury: 5-27-46 1A M.
 (b) Where did injury occur: Lane off Liberty Road below

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?

(d) Means of injury:

23. Signature: Howard Madcis, M.D.
 Medical Examiner
 Date signed: 5-28-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

17-2

14585

38

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Baltimore

City or town

Towson Pulney Rd.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Highway auto collision

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robert Orrin

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

8. (b) Name of husband or wife Sarah Hinton Hall

7. Birth date of deceased (mo., day, yr.)

February 3, 1914

8. (c) If alive, give age 29 years

8. AGE:

Years
32Months
3Days
23

If less than one day

hrs. min.

8. Birthplace

Monkers, N.Y.

(Town, county, and state)

10. Usual occupation

Insurance Agent

11. Industry or business Wash. Natl. Ins. Co.

FATHER

12. Name Fred W. Hall

MOTHER

13. Birthplace Providence, R.I.

Lillian Mills

15. Birthplace

Burlington, Wis.

18. Informant

Mrs. Sarah H. Hall

Address 32 Northwood Drive, Timonium, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof May 28, 1946

(month) (day) (year)

Cemetery or crematory Frank E. Remington

Location 1604 Broad St., Providence, R.I.

18. Funeral director

John Burns Sons

Address

Towson, Maryland

19. May 28, 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore

City or town 32 Northwood Drive

(If outside city or town limits, write RURAL and give nearest town)

Street No. Timonium

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h.

19... to 19...

Immediate cause of death

Fractured skull

Compound fracture cranium

Fractured neck, cardio-thoracic junction

DURATION

5/26/46

5/26/46

5/26/46

Due to Auto accident

Due to

Other conditions

Deep lacerations thigh muscles

5/26/46

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident Date pt 5/26/46

Where did injury occur

Towson City or town

Baltimore County

Md. State

Injured at home, farm, industry, public place (where?)

P.M. on highway Pulney Rd

Means of injury

Auto accident collision

Killed at work

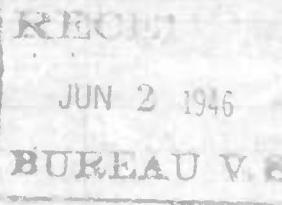
23. SIGNATURE

Bolin L. Hudson M.D. D.M.E.

M. D. or other

Towson 4, Md. Date signed 5/26/46

Registar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3rd

CERTIFICATE OF DEATH

14587 KK
Reg. Dist. No.

1. PLACE OF DEATH:
County.....
City or town.....

Fort Howard, Md.
Fort Howard, md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Veteran's Hospital

How long in hospital or institution?

3. (a) FULL NAME

Thomas F. Hand.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife.....

Margaret Catherine

7. Birth date of deceased (mo., day, yr.) June 7, 1874
6.(c) If alive, give age..... years8. AGE: Years Months Days If less than one day
71 11 24 hrs. min.9. Birthplace..... Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation..... retired

11. Industry or business

12. Name ?

13. Birthplace ?

14. Maiden name ?

15. Birthplace ?

16. Informant..... Mrs. M. Catherine Hand

Address 3502 Keene Avenue 14

17. Burial Date thereof..... 5/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Baltimore National

Location..... Baltimore

18. Funeral director..... Leonard J. Ruck

Address 5305 Harford Road 14

19. 5/13/46
(Registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No..... 3502 Keene Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 5/11/46 19..... at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5/11/46 19..... to 5/11/46 19.....
and that I last saw him alive on 5/11/46 19.....

Immediate cause of death.....

Hypernephroma, right kidney, with
infarction

Due to.....

Due to.....

Other conditions Coronary arteriosclerosis?
heart disease

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Leonard J. Ruck, M.D.
Address Fort Howard, Md. Date signed 5/14/46
M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 40
84588

1. PLACE OF DEATH
 County: Balt^o
 City or town: Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, Institution, or street address where death occurred:
 Balt^o
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Md. County: Balt^o
 City or town: Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: ✓
 (If rural, give LOCATION)

3. (a) FULL NAME
 James T. Hauldon ✓

3. (b) Social Security Number

4. Sex: M ✓ 5. Color or race: 6. (a) Single, married, widowed, or divorced: ✓

8. (b) Name of husband or wife: ✓

7. Birth date of deceased (mo., day, yr.): Sept 28 1945
 8. AGE: Years: 7 Months: Days: If less than one day: . hrs. . min.

9. Birthplace: ✓ (Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: Thomas F. Hauldon

MOTHER FATHER: 12. Name: Margaret Cain

13. Birthplace: Md.

14. Maiden name: Margaret Cain

15. Birthplace: Md.

16. Informant: Mr. & Mrs. Hauldon

Address: Fullerton, Md.

17. Burial, cremation, or removal, Which?: Burial Date thereof: May 18 1946
 (month day year)

Cemetery or crematory: St. Johns

Location: Way of Grey Grd.

18. Funeral director: Clifford F. Hudson

Address: Benson and

19. May 18 1946 G. E. Arthur
 (Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that deceased from May 6, 1946 to May 16, 1946 and that I last saw her alive on May 14, 1946.

Immediate cause of death: Bilateral Atrial Thrombosis DURATION 6 days

Due to: Upper Respiratory Infection 12 days

Other conditions: General debility

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of ...

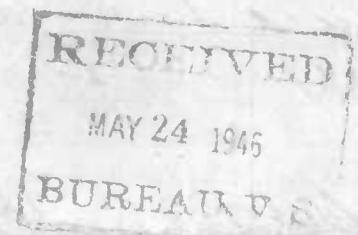
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D. M. D. or other

Address: York, Md. Date signed: May 18 1946



UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	RECEIVED	1 week ago
Run over by street car	JUN 2 1928	1 week ago
Peritonitis	BUREAU	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

CERTIFICATE OF DEATH

04590

Reg. Dist. No. 30

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F W single

6 (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6 (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

87 Not Known

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month)

(day)

(year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 5-18-

(Date rec'd by registrar)

1946

Harold Miller

Registrar

Deputy

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16

1946, A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mo

1946

to

May 16

1946

and that I last saw her alive on May 11, 1946.

Immediate cause of death

Diseases of the heart

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

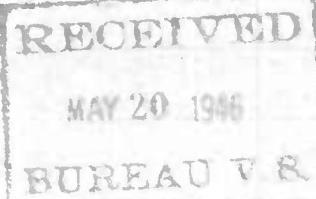
23. SIGNATURE

M. D. or other

Address

Catonsville 28-246

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-B

CERTIFICATE OF DEATH

04591

38

Reg. Dist. No.

1. PLACE OF DEATH:

County 7807 Wilson Ave

City or town Parkville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Eurith E. Hays

Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White married

8. (b) Name of husband or wife

Edgar W. Hays

7. Birth date of deceased (mo., day, yr.)

July 7, 1906

6.(c) If alive, give age 39 years

8. AGE:

Years

Months

Days

If less than one day

39

10

18

hrs.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

12. Name

John R. Osborn

13. Birthplace

Md.

14. Maiden name

Julia Greenfield

15. Birthplace

Md.

16. Informant

Mr. Edgar W. Hays

Address

7807 Wilson Ave Parkville

Burial

Burial

(Burial, cremation, or removal, Which?)

Date thereof 5/28/46

(Month) (day) (year)

Cemetery or crematory

Parkwood

Location

Taylor Ave

18. Funeral director

Howard H. Blight Jr.

Address

6209 Harford Road

19. (Date signed by registrar)

5/28/46 Quigley

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Md.

Parkville

Street No.

7807

Wilson Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 25

19

46

st

3

p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 19, 45, to May 25, 46

and that I last saw her alive on May 19, 46

Immediate cause of death Cardiac failure

DURATION

Due to Rheumatic Valvular Disease

Due to Rheumatic fever

Other conditions Dementia praecox

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Thomas Brennan M. D. or other

Address 5217 Harford Road Date signed May 25, 1946

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 1593

1. PLACE OF DEATH

County

Balto

Village or City

fork P.O.

W.D.

Registration Dist. N.D.

40

St.

Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. If of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

(a) Residence: N.D.

Evelyn Hennessy

St. Ward.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

Sept 27-1868

7. AGE

77

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

OCCUPATION

12. BIRTHPLACE (city or town)

(State or country)

Md

MOTHER FATHER

13. NAME

William Hennessy

14. BIRTHPLACE (city or town)

Ireland

(State or country)

15. MAIDEN NAME

Ann Devaux

16. BIRTHPLACE (city or town)

Ireland

(State or country)

17. INFORMANT

James Hennessy

(Address)

120 S. E. Ave

18. BURIAL, CREMATION, OR REMOVAL

New Cathedral

Place

Date

19. UNDERTAKER

Clarence S. Arthur

(Address)

Balto and

20. FILED

May 18, 1946 C. S. Arthur

Date

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

May 18, 1946
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

, 19_____, to _____, 19_____.
I last saw h. alive on _____, 19_____.; death is said

to have occurred on the date stated above, at _____ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Coronary occlusion
Date of onset
and death

Other Contributory Causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? Was there an autopsy? _____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury _____, 19_____.
Where did injury occur? _____(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____ M. D.
(Signed) _____
(Address) _____ Deputy Medical ExaminerIf more blocks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.
Baltimore, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	Date of onset 1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset 1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 342

14592

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County

Baltimore

City or town

Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred:

405 Central Avenue

How long in hospital or institution?

3. (a) FULL NAME

John Seng Held

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife

Bessie Hook Held

7. Birth date of deceased (mo., day, yr.)

September 18, 1883

8. (c) If alive, give age

63

years

8. AGE:

62

Years

7

Months

29

Days

—

If less than one day

hrs.

—

min.

9. Birthplace

Towson, Balto. Co., Maryland

(Town, county, and state)

10. Usual occupation

Court Librarian

11. Industry or business

Circuit Court, Balto. Co.

MOTHER FATHER

Lewis W. Held

13. Birthplace

Germany

14. Maiden name

Fredericka Breyer

15. Birthplace

Germany

16. Informant

Mrs. John S. Held

Address

405 Central Ave., Towson 4, Md.

17. Burial

Date thereof May 19, 1946

(Burial, cremation, or removal, which)

(month) (day) (year)

Cemetery or crematory

Prospect Hill Cemetery

Location

Towson, Maryland

18. Funeral director

John Burns Sons

Address

Towson, Maryland

19. Date rec'd by registrar

May 19, 1946

f9

We bury now

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 405 Central Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 16, 1946, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 to 19, 1946, to May 16, 1946, and that I last saw him alive on May 16, 1946.

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Dwight H. Hogenson M. D. or other

Address Towson 4 Md. Date signed 5/18/46

RECEIVED

JUN 2 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County

City or town

Balto.

Catoctinville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 mos.

Hospital, institution, or street address where death occurred:

5501 Edmonson Ave

How long in hospital or institution? nursing home 6 mos

3. (a) FULL NAME

Magdalene Hester

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widow

6. (b) Name of husband or wife

G. Lewis Hester

7. Birth date of deceased (mo., day, yr.)

Sept 10. 1877

(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

68

8

13

hrs.

min.

9. Birthplace

Germany

(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

Carl Lehmann

12. Name

Carl Lehmann

13. Birthplace

Germany

14. Maiden name

Emma Baumann

15. Birthplace

Germany

16. Informant

Geo. H. Hester

Address

1306 Northview Road

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 25/46
(month) (day) (year)

Cemetery or crematory

Woodlawn

Location

" Md.

18. Funeral director

John O. Mitchell & Sons

Address

1990 Eutaw Place

19.

5/24/46 A. W. Hester

(Date rec'd by registrar)

J.M. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Balto.

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1306

Northview Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 23 1946 at 7:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 12 1945 to May 23 1946

and that I last saw her alive on May 23 1946

Immediate cause of death

Cerebral hemorrhage

DURATION

1 wk

Due to

Cerebral arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

e4595

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 22 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 4 months, 22 days

3. (a) FULL NAME

Harry E. Hincey

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife..... Valeria Lom

6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) June 21, 19058. AGE: Years Months Days If less than one day
40 10 16 .hrs. .min.9. Birthplace..... Stark County, Ohio
(Town, county, and state)

10. Usual occupation..... Salesman

11. Industry or business..... Liquor

12. Name..... William C. Hincey

13. Birthplace..... Pennsylvania

14. Maiden name..... Katherine Davis

15. Birthplace..... ?

16. Informant..... Hospital records

Address..... Catonsville-28, Md.

17. Burial Date thereof..... May 10-46
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Pittsburgh, Pa.

Location..... Robert Brooks & Son

18. Funeral director..... Colham & Hollins Street

Address..... 5-846 Annapolis
(By registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 719 St. Paul Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... May 7 1946 at 5:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 1945, to May 7, 1946,

and that I last saw him alive on May 7, 1946.

Immediate cause of death..... General paresis (syphilis) DURATION Indefinite

Due to..... Therapeutic malaria 20 days

Due to.....

Other conditions..... Aortitis (luetic?) Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Signature..... Isadore Tuerk, M.D.

M. D. or other..... Date signed.....

Address..... Catonsville-28, Md. 5-7-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

CERTIFICATE OF DEATH

04596

Reg. Dist. No.

1. PLACE OF DEATH: BALTIMORE

County.....

City or town. CHESNUT RIDGE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long to hospital or institution?

3. (a) FULL NAME

JOSEPHINE HOFFMAN

4. Sex

FEM

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

DECEMBER 17-1866

8. AGE:

Years 79	Months 4	Days 17	If less than one day hrs. min.
-------------	-------------	------------	---

9. Birthplace.....

BALTIMORE Co. MD

(Town, county, and state)

10. Usual occupation.....

NONE

11. Industry or business

—

12. Name..... GEORGE HOFFMAN

13. Birthplace..... GERMANY

14. Maiden name..... MARGARET HETRICK

15. Birthplace..... GERMANY

16. Informant..... MRS CHARLES FORWARD

Address..... GREENSPRING AVE LUTHERVILLE P.O.

17. Burial..... Date thereof..... MAY. 6-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... HOLY CROSS.

Location..... A.A.C.

18. Funeral director..... BERNARD E. HARRELL

Address..... 131 E West St

19. (Date filed by registrar) 5/6/46 *Am. Standard*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD

County..... BALTO

City or town. CHESNUT RIDGE

(If outside city or town limits, write RURAL and give nearest town)

Street No..... GREENSPRING AVE

(If rural, give LOCATION) LUTHERVILLE P.O.

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

MAY. 4th 1946 at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-7-46 to 5-25-46 1946

and that I last saw her alive on 5-25-46 1946

Immediate cause of death.....

Myocarditis Chronic - decompensating

DURATION

Due to..... hypertension

arterioclerosis

Due to.....

Other conditions..... ✓

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... James L. Saffell

M.D. or other

Address..... Western Md. Hospital

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04597

33

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:
County..... **Balto.**
City or town..... **Owings Mills**
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **18 yrs**

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... **Md.** County..... **Balto.**
City or town..... **Owings Mills**
(If outside city or town limits, write RURAL and give nearest town)
Street No..... **Pleasant Hill Park**
(If rural, give LOCATION)
2.(a) If veteran, name war..... **None**

3.(a) FULL NAME
Ada Jeanette Holland

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife..... **Walter S. Holland**

7. Birth date of deceased (mo., day, yr.) **May 12, 1884**
6.(c) If alive, give age..... years

8. AGE: Years Months Days It less than one day
62 1 hrs. min.

9. Birthplace..... **Balto. Co.**
(Town, county, and state)

10. Usual occupation..... **Housework**

11. Industry or business
12. Name..... **Cyrus G. Gover**

13. Birthplace..... **Carroll Co.**

14. Maiden name..... **Mary Poole**

15. Birthplace..... **Md.**

16. Informant..... **Lillian Smith**

Address..... **Owings Mills**

17. Burial..... **Burial** Date thereof..... **May 17, 1946**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Reisterstown Methodist**

Location..... **Balto. Co.**

18. Funeral director..... **J.F. Eline & Sons**

Address..... **Reisterstown, Md.**

19. **5-16** 1946 (Date rec'd by registrar) **Mary B. Eline** Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **May 12, 1946** at **3:30 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **5-14-46** 19..... to **5-14-46** 19..... and that I last saw h..... alive on **Not seen alive** 19.....

Immediate cause of death..... **Cerebral Hemorrhage** DURATION **1 hr.**

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **D.D. Caplan, M.D. ex am** M. D. or other

Address..... **Reisterstown, Maryland** Date signed **5-14-46**

MAY 20 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04598

44

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County..... Baltimore
City or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

27 Days

How long in above place of death?..... 27 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.

How long in hospital or institution?..... 27 Days

3. (a) FULL NAME

FLETCHER HOLMES

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife..... Clara Holmes

7. Birth date of deceased (mo., day, yr.)..... August 1, 1898

8. AGE:	Years	Months	Days	It less than one day
	47	9	27	hrs. min.

9. Birthplace..... South Carolina
(Town, county, and state)

10. Usual occupation..... Unemployed

11. Industry or business

12. Name..... Peter Holmes

13. Birthplace..... South Carolina

MOTHER FATHER

14. Maiden name..... Fannie Pope

15. Birthplace..... South Carolina

16. Informant..... Clinical Records, Vets. Adm. Hosp.
Ft. Howard, Maryland

Address.....

17. Burial..... Date thereof..... 6/3/46
(Burial, cremation, or removal, Which?)

Cemetery or crematory..... Baltimore National

Location..... Elroy O. Wilson

18. Funeral director.....

Address..... 1000 Brantley Ave. Balto. Md.

19. Date rec'd by registrar..... June 1, 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1428 Druid Hill Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 28, 1946, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1946, to May 28, 1946,

and that I last saw him alive on May 28, 1946.

Immediate cause of death..... PULMONARY TUBERCULOSIS, ACTIVE 4

DURATION

Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operation.....

Date of op.....

Autopsy results..... Same as Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... F. J. KIAN, M.D., M.C., M.O. or other

Ft. Howard, Md. 5-28-46 D.R.

Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-12

CERTIFICATE OF DEATH

4599

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltimoreCity or town Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

4937 Cedar Ave.

How long in hospital or Institution?

3. (a) FULL NAME

Mary F. Horrmill

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Arvill H.

7. Birth date of

deceased (mo., day, yr.)

July 13, 1865

8. (c) If alive, give age

years

8. AGE:

Years 80Months 10Days 1

If less than one day

hrs.

min.

9. Birthplace West Virginia

(Town, county, and state)

10. Denal occupation Housewife

11. Industry or business

12. Name Isaac Largent13. Birthplace Virginia14. Maiden name Sarah A. Attender15. Birthplace Virginia16. Informant Mrs W. V. WidmeyerAddress 4937 Cedar Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 17, 1946
(month) (day) (year)Cemetery or crematory GreenwayLocation Berkeley Springs West. Virginia18. Funeral director Mary F. WitheAddress 410, E Diamond Ave.19. Date record by registrar May 16

19.

Signature Gertrude Kieffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

BaltimoreCity or town Relay

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4937 Cedar Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14

19

46 at 830 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946, to May 14 1946; and that I last saw her alive on May 13 1946.Immediate cause of death Myocardial infarction
Indirect cause Pulmonary
EdemaDue to Promiscuity +
Obesity
High blood pressureDied on May 14 1946
Afternoon -
Age 81 yrsOther conditions Alcoholism

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

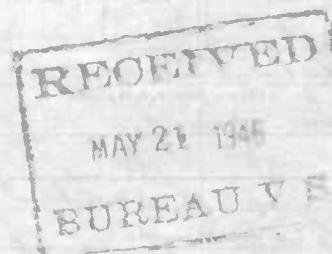
Injured at work?

23. SIGNATURE John Zimmerman

M. D. or other

Address 9858 Harford Date signed May 15/46

1010 See



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04600
Reg. Dist. No. 37

1. PLACE OF DEATH

County Baltimore

City or town Cockeysville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 121 yrs

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Md.

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Willie L. Hutchison

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widow

8. (b) Name of husband or wife

Franklin P. Hutchison

7. Birth date of deceased (mo., day, yr.)

Dec. 11 - 1865

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80

4

23

hrs.

min.

9. Birthplace

Seaford, Delaware

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

James K. Marvel

12. Name Georgetown Delaware

13. Birthplace Alexander Colburn

14. Maiden name Seaford, Delaware

15. Birthplace Laura M. Schaefer

16. Informant Masonic Home, Cockeysville Md.

Address Date thereof May 8/46

(month) (day) (year)

17. Burial (Burial, cremation, or removal. Which?)

Cemetery or crematory Mt. Olivet

Location Frederick Rd

18. Funeral director Mrs. J. Berger Jr.

Address 1512 Hollins St.

19. 576 (Date rec'd by registrar) f. 46

of M. Schaefer
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Baltimore

City or town Baltimore Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3118

Henderson Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 5

19 46 at 7:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec.

19 44 to May 5

19 46

and that I last saw her alive on May 4

19 46

Immediate cause of death

Generalized metastasis

DURATION

1 yrs

Due to

Inoperable Carcinoma of

Due to left Breast

2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

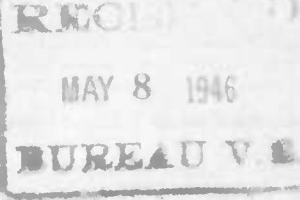
23. SIGNATURE

Solomon Sherman M.D.

M. D. or other

Address 3424 Eutaw Pl.

Date signed 5/5/46



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-8

04601

32

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 1 mo. 12 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 1 yr. 1 mo. 12 days

3. (a) FULL NAME

Mrs. Rosalie Iczkowski

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife..... Stanley Iczkowski

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

February 8, 1922

8. AGE:

Years

Months

Days

Less than one day

24

2

24

hrs. min.

9. Birthplace..... Eastport, Maryland

(Town, county, and state)

10. Usual occupation..... None

11. Industry or business

12. Name..... Alexander Johnson

13. Birthplace Philadelphia, Pennsylvania

14. Maiden name..... Rosalie Lindeman

15. Birthplace Baltimore, Maryland

16. Informant..... Mrs. Rosalie Iczkowski

Address 907 E. Chase St., Balto., Md.

17. Burial..... Date thereof May 4, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cedar Bluff Cemetery

Location..... Annapolis, Maryland

18. Funeral director..... E. Willis LaMoreau

Address 4510 Liberty Hgts. Ave., Balto., Md.

19. May 2, 1946 Earl T. Webster
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No.... 907 E. Chase Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 2,

1946, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 20, 1945, to May 2, 1946,

and that I last saw her alive on May 2, 1946.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

4 yrs.

6 mos.

Due to..... Tubercle Bacilli

Due to.....

Other conditions..... None

(Include pregnancy within 8 months of death)

Major findings or operations..... No operation

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE..... Stewart S Shaffer M.D.

or other

Address..... Mount Wilson, Md. Date signed 5/12/46

Recd

5-3-46 Dr E. Nichols

MAY 5 1946

BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

CERTIFICATE OF DEATH

(4602 Reg. Dist. No. 32)

1. PLACE OF DEATH:

Baltimore

County

Mount Wilson, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 7 mos., 21 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 2 yrs., 7 mos., 21 days

3. (a) FULL NAME

Thomas Jesionowski

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife Bertha Jesionowski

7. Birth date of deceased (mo. day, yr.) December 29, 1895

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
50 4 19 hrs. min.9. Birthplace Poland
(Town, county, and state)

10. Usual occupation Tailor

11. Industry or business

12. Name Wojcieck Jesionowski

13. Birthplace Poland

14. Maiden name Francis Wolaniec

15. Birthplace Poland

16. Informant Thomas Jesionowski

Address 615 S. Montford Ave., Balto., Md.

17. Burial Date thereof May 21, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Rosary Cemetery

Location German Hill Rd., Baltimore, Md.

18. Funeral director Fialkowski Funeral Home

Address 2007 Eastern Ave., Balto., Md.

19. May 18, 1946 Earl T. Webster
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 615 S. Montford Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 18,

1946, 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 27, 1943, to May 18, 1946,

and that I last saw him alive on May 18, 1946.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

7 Yrs.

Due to Tubercl Bacilli

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings or operations No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

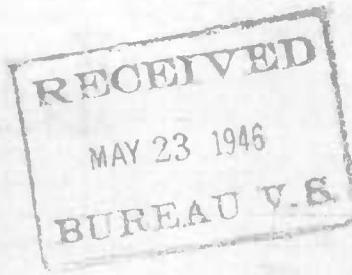
Means of injury

Injured at work?

23. SIGNATURE

Stewart S Shaffer M.D. or other

Address Mount Wilson, Md. Date signed 5/18/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 300

CERTIFICATE OF DEATH

04603

Reg. Dist. No. 30

1. PLACE OF DEATH:

Baltimore

County.

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs., 10 mos., 26 days.

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 6 yrs., 10 mos., 26 days.

3.(a) FULL NAME

William Jett

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white single

6.(b) Name of husband or wife -

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1892

8. AGE: Years Months Days If less than one day
54 1 4 hrs. min.9. Birthplace Calvert County, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER 12. Name Louis Jett

13. Birthplace Readsville, Virginia

14. Maiden name Margaret Watson

15. Birthplace Prince George's Co., Md.

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof 5-19-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Broom's Island Cemetery

Location

18. Funeral director Robert Blackness

Address Prince Georges Co. Md.

19. 5-18-46 Harry L. Miller
(At time of registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert

City or town Brome's Island
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1946 at 5:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20 1939 to May 16 1946

and that I last saw him alive on May 16 1946

Immediate cause of death

Broncho pneumonia

DURATION

4 days

Due to

Due to

Other conditions General paresis

Indefinite

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

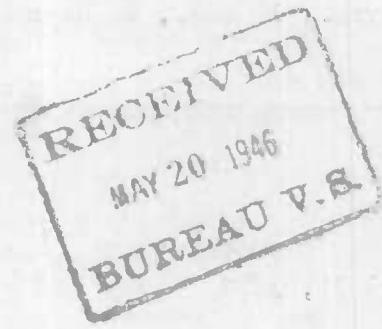
Means of injury

Injured at work?

23. SIGNATURE Isadore Tuerk, M.D.

M. D. or other

Address Catonsville-28, Md. Date signed 5-16-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

04604

37

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Balto.

Phoenix Md.

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 11 yrs. 6 mos.

3. (a) FULL NAME

Winfield Royton King.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White

Married -

6 (b) Name of husband or wife

Ethel Turnbull King.

7. Birth date of deceased (mo., day, yr.)

Oct 29 / 1886.

6(c) If alive, give age 54 years

8. AGE:

Years 59

Months 6

Days 24

If less than one day

hrs.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual occupation

Printer -

11. Industry or business

Printer -

MOTHER FATHER

12. Name

Edwin W. King -

13. Birthplace

Balto. Md.

14. Maiden name

Olivia Bishop -

15. Birthplace

Balto. Md.

18. Informant

Mrs Ethel King

Address

Phoenix. Md.

17. Burial

Date thereof May 26 1942

(Burial, cremation, or removal Which?)

(month)

(day)

(year)

Cemetery or crematory

Fairview

Location

Dunwoody Md.

18. Funeral director

Delaware Corp.

Address

2324 1/2 Charles St.

19. Date rec'd by registrar

May 26

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

Balto.

City or town Sunnybrook

Ward No.

Street No. 10 Phoenix

Ward

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 23 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 1946 to May 23 1946 and that I last saw him alive on May 22 1946

Immediate cause of death

Myocarditis

DURATION

3 yrs.

Due to

Chronic nephritis

4 yrs

Due to

Other conditions

Hypertension

PHYSICIAN

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wilmor C. Forni M.D.

M. D. or other

Address

Cockeysville Md.

Date signed 5/26/46

✓ 9
81419

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04605

Reg. Dist. No.

30

1. PLACE OF DEATH:

County.....

Baltimore Md.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

16. Ducting Ave.

How long in hospital or institution?

of 3 1/2 months

3. (a) FULL NAME

Mabel Belle Koch

3. (b) Social Security Number

4. Sex:

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife.....

Daniel Jacob Koch

7. Birth date of deceased (mo., day, yr.)

August 11/1878

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
67	8	26	hrs. min.

9. Birthplace.....

Illinois

(Town, county, and state)

10. Usual occupation.....

At home

11. Industry or business

Stephen Meyer

12. Name.....

Perma

13. Birthplace

Penns

14. Maiden name.....

Hannah McKinney

15. Birthplace

Penns

16. Informant.....

Harry H. Koch

Address 300 College Ave State College Pa.

17. Burial

Date thereof May 10/1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory.....

Millheim

Location.....

Millheim Pa.

18. Funeral director.....

Harry H. Annacox

Address 4204 Ridgewood Ave

5/8/46 19.....

(Date read by registrar)

Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 1 1946 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 29 1945 to May 7 1946

and that I last saw h. ex. alive on May 7 1946

Immediate cause of death.....

Pulmonary edema

Due to.....

Atherosclerotic Hypertension

cardiovascular renal disease

DURATION

2

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John J. Brown M. D. or other

Address 20 E. Preston St. Balt. Md. Date signed.....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Mc

CERTIFICATE OF DEATH

(Reg. Dist. No. 44)

1. PLACE OF DEATH:

County.....

City or town..... Sparrows Pt. Md.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph Kotzum

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

W.

Married

B. (b) Name of husband or wife..... Rose Kotzum

7. Birth date of deceased (mo., day, yr.)

deceased (mo., day, yr.)

May 12, 1895

6. (c) If alive, give age..... 47 yrs years

8. AGE:

Years

Months

Days

If less than one day

57

1

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Baltimore Md.

10. Usual occupation.....

Machine helper

11. Industry or business.....

Ship Building

12. Name.....

Joseph Kotzum

13. Birthplace.....

Croatia

14. Maiden name.....

Not known

15. Birthplace.....

Austria

16. Informant.....

Rose Kotzum

Address.....

917 Collegeton a

17. Burial.....

Date thereof..... 5-16-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Holy Redeemer

Location.....

Balt Md

18. Funeral director.....

Vernon Brack & Son

Address.....

900 N. Chester St 5

19. (Date rec'd by registrar)

5/14/46 Aufholand

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

5-13-46

19.....

at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to

19.....

and that I last saw h..... alive on

Immediate cause of death.....

Coronary Occlusion

DURATION

10 min

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

W.D. or other

Address..... Date signed.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16-2

04607

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Lorraine Edith Lang

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

—

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Jan 18 1941

8. (c) If alive, give age.....years

8. AGE: Years

Months

Days

If less than one day

....hrs.min.

9. Birthplace.....

Baltimore

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....

Hermann Lang

13. Birthplace

Baltimore

MOTHER

14. Maiden name.....

Edith Badice

15. Birthplace

Pennsylvania

16. Informant.....

Lorraine Lang

Address 60 Portship Rd

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 21-

(month)(day) (year)

Cemetery or crematory.....

Oak Lawn Cem

Location.....

City

18. Funeral director.....

Kleinhans Funeral Home

Address

200 S Orleans St

19. (Date rec'd by registrar)

5/21/46 J. M. Lorraine

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Baltimore

City or town.....

Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

60

Portship

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 18 1946 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1946 to May 18 1946,

and that I last saw h.....alive on

Immediate cause of death.....

Hemangiulation

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Hemangiulitis Date of op. _____

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

5-18-46

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

None

Means of Injury.....

Strangled in Muons Injured at work?

23. SIGNATURE

John Edward Baker, M.D.

Address: 201 S. Charles St., Baltimore, Md. Date signed: 5-20-46

RECEIVED

MAY 30 1945

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

Baltimore
County.....Raspeburg Baltimore 6 Md
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

6813 Golden Ring Road

How long in hospital or institution?.....

3. (a) FULL NAME

Caroline V Lantz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Widowed

6. (b) Name of husband or wife..... Charles W. Lantz

7. Birth date of deceased (mo., day, yr.) May 19, 1862
8. (c) If alive, give age years8. AGE: Years Months Days If less than one day
83 11 20 hrs. min.9. Birthplace..... Baltimore Co. Md.
(Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business.....

12. Name..... Henry J. Volz
FATHER

13. Birthplace..... Germany

MOTHER

14. Maiden name..... Unknown

15. Birthplace.....

16. Informant..... Mrs Henry E Zang
Address 6813 Golden Ring Road17. Burial..... Date thereof..... 5/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Zion Lutheran

Location..... Stemmers Run

18. Funeral director..... Lazarus Funeral Home

Address 7401 Belair Road

19. Date rec'd by registrar..... May 11-1946
VS A15

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County..... Baltimore

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No..... As in No 1
(If rural, give LOCATION)

2.(a) If veteran, name war..... No

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 9, 1946, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to May 9, 1946 and that I last saw her alive on May 9, 1946.

Immediate cause of death..... Semmelweis

DURATION.....

Due to..... agn

Due to.....

Other conditions..... Asternal Detoxicosis

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

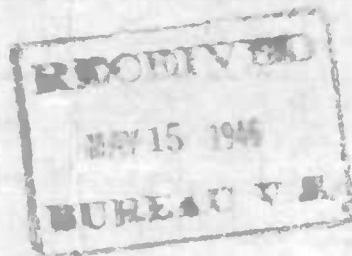
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature..... John H. Pearce M. D. or other

Address..... 2105-B Clark St Date signed May 19, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13a

CERTIFICATE OF DEATH

C4609
Reg. Dist. No.

43

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life

Hospital, institution, or street address where death occurred:

7401 Belair Road

How long in hospital or institution?

3. (a) FULL NAME

HENRY C. LASSAHN

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

B.(b) Name of husband or wife..... Marie C. Lassahn

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... September 9, 1881

8. AGE: Years Months Days If less than one day
64 8 12 hrs. min.9. Birthplace..... Balto. Co., Md.
(Town, county, and state)

10. Usual occupation..... Funeral Director & Embalmer

11. Industry or business

12. Name..... Frederick W. Lassahn

13. Birthplace..... Baltimore, Md.

14. Maiden name..... Eliza M. Duemer

15. Birthplace..... Germany

16. Informant..... Mrs. Henry C. Lassahn

Address 7401 Belair Rd., Balto. 6, Md.

17. burial..... Date thereof..... May 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Loudon Park

Location..... Baltimore, Md.

18. Funeral director..... Geo. L. Berger Jr.

Address 1512 Hollins St.

19. May 22, 1946..... Date record by registrar.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Balto.

City or town..... Raspeburg

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 7401 Belair Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 21, 1946, at 8:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10, 1946, to May 21, 1946,

and that I last saw him alive on May 21, 1946.

Immediate cause of death.....

Cerebral hemorrhage

DURATION

40 hours

Due to..... Valvular heart disease - mitral stenosis & insufficiency

15 years

Due to.....

Other conditions..... Chronic interstitial nephritis

10 years (?)

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

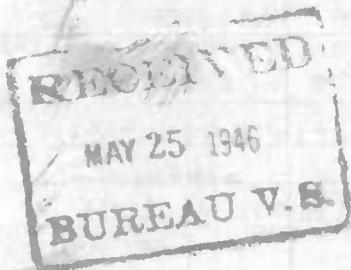
Injured at work?

23. SIGNATURE.....

Adam Glavis

M. D. or other

Address 6232 Belair Road Date signed May 21, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Rd*

64610

CERTIFICATE OF DEATH

Reg. Dlat. No. *38*

1. PLACE OF DEATH:

BALTIMORE

County

TOWSON

City or Town

(If outside city or town limits, write RURAL and give nearest town)

Since April 19, 1946

How long in above place of death?

Hospital, institution, or street address where death occurred:

SHEPPARD AND ENOCH PRATT HOSPITAL

How long in hospital or institution? Since April 19, 1946

3. (a) FULL NAME

MIRIAM LAZARUS

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 15, 1928

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

hrs. min.

9. Birthplace

Baltimore City, Maryland

(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

12. Name

Isaac Lazarus

MOTHER FATHER

13. Birthplace

Knoxville, Tenn.

MOTHER

14. Maiden name

Sophia Berman

15. Birthplace

Baltimore City, Md.

16. Informant

HOSPITAL RECORDS

Address

Towson 4, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

5-12-46

Cemetery or crematory

Baptist Cemetery

Location

Jack Lewis Inc.

18. Funeral director

Address 1439 E. Balt. St

19.

1946

(Date rec'd by registrar)

Curved signature
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2822 Cold Spring Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 9 1946 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 1946 to May 9 1946

and that I last saw her alive on May 9 1946

Immediate cause of death

Chronic endocarditis

DURATION

4 yr.

Due to Acute rheumatic fever

4 yr.

Due to

Other conditions

Depressive psychosis

6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

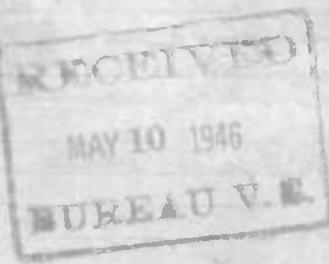
23. SIGNATURE

W. W. Elgin

M. D. or other

Address TOWSON, MD.

Date signed May 9 1946



Evidence for addition of name
of town where death occurred is
shown on
FILM NO. 104 MAY 15 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1946

04611

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: 71 Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1946, to May 5, 1946, and that I last saw him alive on May 4, 1946.

Immediate cause of death

Cerebral Hemorrhage 2 days

Due to Hypertensive Cardio-Vascular Disease 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04612

Reg. Dist. No. 41

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Dundalk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Athalia A. Lloyd

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife..... William I. A. Lloyd

7. Birth date of deceased (mo., day, yr.) August 22, 1873

8. AGE: Years Months Days If less than one day
72 8 22 hrs. min.9. Birthplace..... Wilmington, Del.
(Town, county, and state)

10. Usual occupation..... At home

11. Industry or business

12. Name..... Georg Alden

13. Birthplace..... Delaware

14. Maiden name..... --

15. Birthplace..... --

16. Informant..... Mrs. Mary Geiger

Address..... 3011 Dundalk Ave.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof..... May 17, 1946

(month) (day) (year)

Cemetery or crematory..... Bethel Cemetery

Location..... Chesapeake City, Md.

18. Funeral director..... Ullrich Funeral Home

Address..... 2008 Orleans St.,

19. (Date rec'd by registrar) 5-16 '46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Dundalk, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 12 Kinship

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... MAY 14th 1946 at 9:40 AM

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14th 1946 to May 14th 1946and that I last saw him alive on May 14th 1946

Immediate cause of death..... Adc-t. Disease

DURATION

4 days

Due to..... Acute Cardiac Dilatation
C Pulmonary Edema

4 hrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

M. D. or other

Address..... Dundalk - Md. 5-16

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

CERTIFICATE OF DEATH

04613

44

Reg. Dist. No.

1. PLACE OF DEATH:

Baltimore
Middle RiverCity or town
(If outside city or town limits, write RURAL and give nearest town)

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 13-1

64614 33 p
Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore(b) City or town Prestonstown(c) Street address, hospital, or institution: Art. Pleasant Sanatorium(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in this community (yrs., mos., or days) _____

3 (a) FULL NAME

Harry Londer

3 (b) If veteran, name war

3 (c) Social Security

No. _____

4. Sex

Male

5. Color or race

white

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Bessie Abbott Londer6. (c) If alive, give age 40 years7. Birth date of deceased (mo., day, yr.) March 9, 18978. AGE: Years 49 Months 2 Days 9 If less than one day
hr. _____ min. _____9. Birthplace Russia
(Town, county, and state)10. Usual occupation Grocer

11. Industry or business

12. Name Michael Londer13. Birthplace Russia14. Maiden Name Ella ?15. Birthplace Russia16 (a) Informant Bessie Londer (wife)(b) Address 4015 Fairfax Road.17 (a) Burial Burial (b) Date thereof 5-20-46
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory Bethel Free MethodistLocation Mulberry & Conduit St.18 (a) Funeral director Paul Lewis(b) Address 11439 E. Baltimore St.19 (a) (Date rec'd by registrar) 5/20/46 Death record

Registrar

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County _____(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4015 Fairfax Road

(If rural, give location)

(e) If foreign born, how long in U. S. A? 3 3 years

MEDICAL CERTIFICATION

20. Date of death May 18, 1946, at 12 05 A.M.21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 1946, to May 18, 1946, and that I last saw him alive on May 18, 1946.

Immediate cause of death

Myocardial Collapse

Duration

Due to Congestive Heart Failure

2 weeks

Pneumonia

10 weeks

Due to Pulmonary Tuberculosis

15 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Tuberculosis Pectoral on Right. Otherwise same as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature Albert J. Shier M. D. or otherAddress Prestonstown, Md Date signed May 18, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

CERTIFICATE OF DEATH

04615
Reg. Dist. No. 30

I. PLACE OF DEATH:

County.....BaltimoreCity or town.....Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs., 6 mos., 12 days

Hospital, Institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 13 yrs., 6 mos., 12 days

3. (a) FULL NAME

Nicholas Lowry (Stephen Lowry or Larry)

3. (b) Social Security Number

4. Sex male 5. Color or race white 8.(a) Single, married, widowed, or divorced marriedB. (b) Name of husband or wife Bartha Fenger7. Birth date of deceased (mo., day, yr.) January 9, 1898

6.(c) If alive, give age years

8. AGE: Years 48 Months 3 Days 28 If less than one day hrs. min.9. Birthplace Maryland
(town, county, and state)10. Usual occupation Laborer11. Industry or business Post Office12. Name ?13. Birthplace Maryland14. Maiden name ?15. Birthplace Maryland16. Informant Hospital recordsAddress Catonsville-28, Maryland17. Burial Date thereof 5-11-1946
(Burial, cremation, or removal. Which?) Burial (month) (day) (year)Cemetery or crematory Cedar HillLocation A. A. C. Md.18. Funeral director Flynn & FlemingAddress 1476 Light St.19. 5-10 19. 46 as Hedrick Registrar
(Month by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County.....City or town 1218 Marshall Street
(If outside city or town limits, write RURAL and give nearest town)Street No. Baltimore
(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1946 at 1:55 pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1932 to May 7 1946
and that I last saw him alive on May 7 1946Immediate cause of death ConcussionHead of pancreas
with metastasisDURATION
Due to ?
Due to ?
Other conditions ?

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?Signature Isadore Tuerk, M.D.
M. D. or other Dr. Isadore TuerkCatonsville-28, Md. 5-9-46
Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

64616

Reg. Dist. No.

44

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

1 day

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.

1 day

How long in hospital or institution?

3. (a) FULL NAME

LOYD, George

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Divorced

6.(b) Name of husband or wife.....

Divorced

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

4-9-82

8. AGE:

Years
64Months
1Days
11If less than one day
hrs. min.

9. Birthplace.....

(Town, county, and state) Jones County, Ga.

10. Usual occupation.....

Retired from U.S. Army

11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 5-27-46

(month) (day) (year)

Cemetery or crematory.....

Location..... Jones County, Ga.

18. Funeral director..... Charles E. Lew

Address..... 802 Madison Ave. Balto. Md.

19. May 25 t9 46

(Date rec'd by registrar)

a. W. Hedrick

Registrar

Robert M. Cullison, M. D.

M. D. or other

Address..... Fort Howard, Md.

Date signed..... May 21, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1714 W. Mosher Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 20

t9 46 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 46 to May 20 46

and that I last saw him alive on May 20 t9 46

Immediate cause of death.....

BRONCHOPNEUMONIA, BILATERAL

DURATION

Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

R. M. CULLISON, M. D.

M. D. or other

Address..... Fort Howard, Md.

Date signed..... May 21, 1946

1804 Hillside Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4D

04617

CERTIFICATE OF DEATH

Reg. Dist. No. 3d

1. PLACE OF DEATH:

County..... Baltimore
City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs., 6 mos., 19 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 12 yrs., 6 mos., 19 days

3. (a) FULL NAME

Noble Mallonee

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife: -

7. Birth date of deceased (mo., day, yr.) February 9, 1886

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
60 3 12 hrs. min.9. Birthplace..... Maryland
(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business..... Farm

12. Name..... Oliver W. Mallonee

13. Birthplace..... Maryland

14. Maiden name..... Lavinia Beavin

15. Birthplace..... Maryland

16. Informant..... Hospital records

Address..... Catonsville-28 Md.

17. Burial (Burial, cremation, or removal) Which? Date thereof (month) (day) (year)
Date thereof May 26, 1946

Cemetery or crematory..... Troy Hill Cemetery, Laurel

Location..... Troy Hill Cemetery, Laurel, Md.

18. Funeral director..... J.W.R. Selby

Address..... 401 Washington Blvd Laurel, Md.

19. 15-25 1946 Harry J. Miller
(Fill in by registrar) Sept. 1946 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince George

City or town..... Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH May 21 1946, at 9:00 p.m.

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from November 2, 1933, to May 21, 1946.

and that I last saw him alive on May 21, 1946.

Immediate cause of death.....

Carcinoma of the liver,
source undetermined

DURATION

Indefinite

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

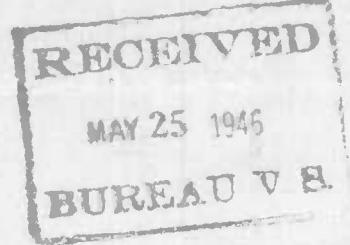
Injured at home, farm, industry, public place (where?)

Means of Injury..... Doctor Isadore Tuerk, M.D.
Injured at work?

23. SIGNATURE..... Isadore Tuerk, M.D.

M. D. or other
Catonsville-28, Md. Date signed
5-22-46

Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

64618 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Obst. Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widow

T

Leigh

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Feb 1 1857

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

04619

CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH:

County *Baltimore*City or town *Evergreen Farm*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Bach River Neck Rd.

How long in hospital or Institution?

3. (a) FULL NAME

*Joseph Matthew*4. Sex *M*5. Color or race *W*6.(a) Single, married, widowed, or divorced *single*6.(b) Name of husband or wife *-*

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age *1888* years8. AGE: Years *58*

Months

Days

If less than one day

hrs. min.

9. Birthplace *Baltimore Co. Md.*

(Town, county, and state)

10. Usual occupation *Farmer*11. Industry or business *-*

FATHER

12. Name *John J. Matthew*13. Birthplace *Austria*14. Maiden name *Unknown*15. Birthplace *-*16. Informant *James Matthew*Address *Evergreen Farm*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *5/15/46*

(month) (day) (year)

Cemetery or crematory *Bethany Cemetery*Location *Baltimore Rd.*18. Funeral director *John J. Connolly*Address *410 Eastern Ave - Greektown*19. Date rec'd by registrar *May 14 1946*19. Date rec'd by registrar *May 14 1946*

Register

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md*County *Baltimore*City or town *Bach River Neck Rd.*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Evergreen Farm*

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 12* 19 *46*, at *1:00 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *October 45* to *May 12, 1946*and that I last saw him alive on *May 11* 19 *46*Immediate cause of death *Chronic valvular heart disease* DURATION *?*Due to *Pulmonary oedema* 24 hrsDue to *Chronic alcoholism* ?Other conditions *Arteriosclerosis* ?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *J. J. Connolly Jr. M.D.* Injured at work?23. SIGNATURE *J. Benedict Branum, M.D.* M. D. or otherAddress *3037 O'Donnell St.* Date signed *MAY 14 1946*Date signed *MAY 14 1946*

3037 O'Donnell St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CORRECTED COPY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County..... Baltimore
City or town..... Fort Howard (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 103 days
Hospital, institution, or street address where death occurred: Vets. Adm. Hosp. Ft. Howard, Maryland
How long in hospital or institution?..... 103 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County.....
City or town..... Gambrells (If outside city or town limits, write RURAL and give nearest town)
Street No..... (If rural, give LOCATION)
2.(a) If veteran, name war..... S.A.W.

3. (a) FULL NAME

James A. Matz
4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced
Married

6.(b) Name of husband or wife..... Carrie E. Matz
7. Birth date of deceased (mo. day, yr.)..... Nov. 27, 1878 6.(c) If alive, give age..... 61 years

8. AGE: Years..... 67 Months..... 5 Days..... 15 If less than one day
hrs..... min.....

9. Birthplace..... Reading, Pa. (Town, county, and state)

10. Usual occupation..... Unemployed

11. Industry or business

12. Name..... Jim Matz
13. Birthplace..... Pennsylvania

MOTHER FATHER
14. Maiden name..... Annie Ziegler
15. Birthplace..... Reading, Pa.

16. Informant..... Clinical Records, Vets. Adm. Hosp
Address..... Fort Howard, Maryland

17. Burial..... Cemetery Date thereof..... 5-14-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cemetery
Location..... Reading, Pa.

18. Funeral director..... Oder Funeral Home, Inc.
Address..... 4644 York Rd., Baltimore, Md.

19. 5-14-46. Date rec'd by registrar..... A.W. Mednick
(Date rec'd by registrar) (Signature) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 13, 1946 at 6:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30, 1946 19..... to May 13, 1946 19.....
and that I last saw him alive on May 13, 1946 19.....

Immediate cause of death..... Heart Disease 93d DURATION
Hypertension and coronary myocardial Since
insufficiency, auricular fibrilla 93d Dec. 26, 44
tion.

Due to..... 93d

Other conditions..... Nephrosclerosis 131a

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Robert M. Cullison M.D. or other

R. M. CULLISON, M.D. CLIN. DIR.
Address..... Ft. Howard, Md. Date signed 5-13-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136-21

04621 P

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

17 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, Maryland

How long in hospital or institution?

17 days

3. (a) FULL NAME

LEVI MAXWELL

4. SEX

Male

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Loretta Maxwell

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.)

December 25, 1888

8. AGE:

Years

3

Months

4

Days

7

If less than one day

hrs.

min.

9. Birthplace Georgia

(Town, county, and state)

10. Usual occupation Fireman

11. Industry or business

Levi Maxwell

12. Name

MOTHER FATHER

Levi Maxwell

13. Birthplace

Georgia

14. Maiden name

Lucy Foster

15. Birthplace

Georgia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 6 1946

(month) (day) (year)

Cemetery or crematory National CemeteryLocation Fort Howard18. Funeral director Mrs. Katie R. Williams

Address

322 N. Schroeder St

19. Date record by registrar

5/4/46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 243 N. Schroeder St.

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2

19.46 at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15,

19.46 to May 2 19.46

and that I last saw him alive on May 2

19.46

Immediate cause of death

Uremia, chronic, severe

DURATION

6mos.plus

Due to Stricture of posterior urethra severe 6 yrs.Due to Bilateral Hydronephrosis 2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature Robert M. Cullison M. D. or other
ROBERT M. CULLISON, CLINICAL DIRECTORAddress Fort Howard, Maryland

Date signed 5-2-46

Evidence for change of MARYLAND STATE

& birth date of deceased is shown in CITY HEALTH DEPARTMENT

FILM No. I 04 MAY 15 1946

CERTIFICATE OF DEATH

Registered No. 38

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

Parkville

(b) Street address.....

3010 Lavender Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

3 (a) FULL NAME

Elizabeth Meyers

3 (b) If veteran, name war

no

3 (c) Social Security Account

No. 700

4. Sex

Female white

5. Color or race

6 (a) Single, married, widowed, or divorced.

widowed

6 (b) Name of husband or wife

John H. Meyers

6 (c) If alive, give age years

March 21-1858

1859

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days

If less than one day

87 88 1 15

hr. min.

9. Birthplace.....

Unknown

(Town, county, and state)

10. Usual Occupation.....

Housework

11. Industry or business

12. Name.....

Peter Gohs

13. Birthplace.....

Germany

14. Maiden Name.....

Unknown

15. Birthplace.....

Unknown

16 (a) Informant

Mrs John St. Meyer Jr

(b) Address

3010 Lavender Ave

17 (a) Burial

(b) Date thereof 5-8-46

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Parkwood Cem.

Location Baltimore Md

18 (a) Funeral director

Edward J. Brock

(b) Address

5305 Harford Rd Md

19 (a) Deed rec'd by registrar

(b) H. W. Harck

(Date rec'd by registrar)

Registrar

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADED INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2. USUAL RESIDENCE OF DECEASED:

(a) State

Md.

(b) County

04622

(c) City or town

Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1767 Garfield Ave

(If rural give location)

(e) Citizen of foreign country?

If yes, name country.

(Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 6 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1946, to May 6 1946, and that I last saw her alive on May 5 1946.

Immediate cause of death

Bronchitis Pneumonia

Hemorrhage

Due to Mental degeneration Henry

request to Dr. L. A. Stevens

Due to Dr. L. A. Stevens nephritis

Duration

3 d.

5 d.

14 d.

14 d.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work? (Specify type of place)

(e) Means of injury

23. Signature G. F. A. Stevens

Address 2818 Harford Rd M.D.

Date signed May 7 1946

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

+2⁴⁴
Reg. Dist. No.

CERTIFICATE OF DEATH

72643

C4623

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Baltimore
 (a) County _____
 (b) City or town Dundalk
 (c) Street address, hospital, or institution: 1815 East Ave.
 (d) Length of stay in hospital or inst. (yrs., mos., or days) _____
 (e) Length of stay in this community (yrs., mos., or days) _____

2. HOME (USUAL RESIDENCE) OF DECEASED:
 (a) State Md. (b) County Balto.
 (c) City or town _____
 (d) Street No. 1815 East Ave Dundalk
 (e) If foreign born, how long in U. S. A.? _____ years

3 (a) FULL NAME Anna May Miller

3 (b) If veteran, name war _____

3 (c) Social Security No. _____

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife _____

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19

8. AGE: Years 9 Months _____ Days _____ less than one day hr. _____ min. _____

9. Birthplace Baltimore
(Town, county, and state)

10. Usual occupation School girl

11. Industry or business _____

12. Name John H. Miller

13. Birthplace Baltimore

14. Maiden Name Sophie K. Lelewski

15. Birthplace Baltimore

16. (a) Informant John H. Miller
(b) Address 1815 Easton Dundalk

17. (a) Burial Cremation (b) Date thereof June 3/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cemetery
Location Baltimore

18. (a) Funeral director Fred J. O'Gorman
(b) Address 1930 Fulton St

19. (a) Date rec'd by registrar June 11, 1946 (b) A. W. Hedges
Registrar per Dr. [unclear]

MEDICAL CERTIFICATION

20. Date of death May 31 1946, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945, to May 31 1946, and that I last saw him alive on May 31 1946.

Immediate cause of death Toxemia Duration 1 yr.

Due to Tumorous growths with general metastases Duration 2 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature Geo. M. Baumgardner M.D. or other

Address Balto 6 Md Date signed 5-31-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Date No. 4624

44

1. PLACE OF DEATH:
Baltimore County

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, Maryland

How long in hospital or institution? 3 Days

3. (a) FULL NAME

CLARENCE E. MOSER

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
-------------	------------------------	--

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) August 1, 1892

8. AGE: Years 53	Months 9	Days 26	If less than one day hrs. min.
------------------	----------	---------	--

9. Birthplace Myersville, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business Unknown

MOTHER FATHER 12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Ft. Howard, Md.

17. Burial Date thereof 30-May-46
(Burial, cremation, or removal, Which?)

Cemetery or crematory Hagerstown, Maryland

Location

18. Funeral director Oder Funeral Home One

Address 4644 York Rd.

19. 5/28/46 D.W. Reddick
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County W.M.D.

City or town Newville - Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name was * WW-I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1946 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24, 1946, to May 27, 1946,

and that I last saw him alive on May 27, 1946.

Immediate cause of death Coronary Arteriosclerotic Heart Disease

DURATION Unknown

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F.J. RYAN, M.C., U.S.A.F. REG'D. CHIR. DIR.

Address V.A. Ft. Howard, Md. Date signed 5-27-46

Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 230

CERTIFICATE OF DEATH

04625

Reg. Dist. No.

33

1. PLACE OF DEATH:

County

Baltimore
REISTERSTOWN

City or town

(If outside city or town limits, write RURAL and give nearest town)

3 WKS

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Now long in hospital or institution?

3. (a) FULL NAME

Christina C. Newbig

3. (b) Social Security Number

Sex

5. Color or race

FEMALE white Widow

6.(a) Singin, married, widowed, or divorced

6.(b) Name of husband or wife

John J. Newbig

MARCH 1887

5.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
59 2 hrs. min.9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

NONE
ANTON VOLKERT

12. Name

GERMANY

13. Birthplace

14. Maiden name

?

15. Birthplace

16. Informant

GEORGE A. BECK

Address 1525 W. PRATT ST

17. Burial

Date thereof MAY 17-1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

WESTERN

Location

BALTIMORE MD

18. Funeral director

BELL & B. M. WALTERS

Address

PRATT & STOCKER ST

19. May 25 1946
(Date rec'd by registrar)VS A15
9. W. H. Hirsch
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORE

City or town REISTERSTOWN
(If outside city or town limits, write RURAL and give nearest town)Street No. CHROME MINE ROAD
(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 24 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-8-46 19. to 5-24-46 19.

and that I last saw her alive on 5-24-46 19.

Immediate cause of death

Cardiac Decompenstation 2 weeks

Due to Hypertension & V. Disease 1 yr.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. D. Caples, M.D.
M. D. or other

Address Rusticaway Rd. Date signed 5-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

64626

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 50 years

Hospital, institution, or street address where death occurred:

Corky's Hill Road

How long in hospital or institution?

3. (a) FULL NAME

Jefferson Davis Norris

4. Sex
male5. Color or race
white6.(a) Single, married, widowed, or divorced
widowed

6.(b) Name of husband or wife..... Martha Cabell Perkins

7. Birth date of
deceased (mo., day, yr.)

Sept 2, 1865

6.(c) If alive, give age..... deceased years

8. AGE:

Years
80Months
8Days
28If less than one day
hrs. min.

9. Birthplace.....

Reisterstown Baltimore Co., Md.

(Town, county, and state)

10. Usual occupation..... Lawyer (retired)

11. Industry or business

12. Name..... William Norris

13. Birthplace..... Reisterstown, Md.

14. Maiden name..... Ellen Lyle Hobson

15. Birthplace..... Valparaiso Chile, S. A.

16. Informant..... Martha J. Norris

Address

Reisterstown, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... June 1, 1946

(month) (day) (year)

Cemetery or crematory..... Cemetery

Location..... All Saints cemetery Reisterstown

18. Funeral director..... William Berryman & Sons

Address..... Reisterstown, Md.

19. 5 - 31 - 1946
(Date rec'd by registrar)Mary B. Eline
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Baltimore

City or town..... Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Corky's Hill Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 30 1946 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1935 to May 30, 1946
and that I last saw her alive on May 29, 1946

Immediate cause of death..... Myocarditis

Due to..... Arterio-Sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

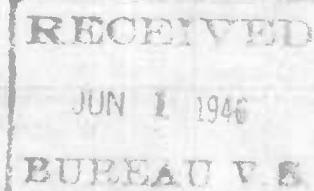
Injured at work?

23. SIGNATURE..... M. D. or other

Address..... 1403 Park Ave. Date signed..... 5/31/46

STATE TO STATE MAIL

STATE TO STATE MAIL



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-6

04627

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 1 mo., 11 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 1 mo., 11 days

3. (a) FULL NAME

James Thomas Nunnelley

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 18, 1920

8. AGE: Years Months Days If less than one day
26 3 17 hrs. min.9. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation..... Salesman

11. Industry or business

12. Name..... James T. Nunnelley

13. Birthplace..... Irvin, Kentucky

14. Maiden name..... Ella Barger

15. Birthplace..... Texas, Maryland

16. Informant..... James Thomas Nunnelley

Address 4214 Cardwell Ave., Fullerton, Md.

17. Burial Date thereof..... May 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parkwood Cemetery

Location..... 3310 Taylor Ave., Balto., Md.

18. Funeral director..... Lassahn Funeral Home
Address 7401 Belair Road, Balto., Md.19. May 5, 1946 (Date rec'd by registrar) Earl W. Webster
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Fullerton (If outside city or town limits, write RURAL and give nearest town)

Street No. 4214 Cardwell Avenue (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

220-01-3761

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1946 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24, 1946 to May 5, 1946 and that I last saw him alive on May 5, 1946.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 Yr.

Due to..... Tubercle Bacilli

Due to.....

Other conditions..... Tuberculous Laryngitis 3 Mos.

(Include pregnancy within 3 months of death)

Major findings or operations..... No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

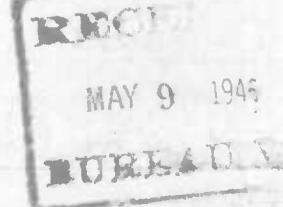
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Stewart S Shaffer M.D. D. or other

Address..... Mount Wilson, Md. Date signed 5/5/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100

CERTIFICATE OF DEATH

04628

Reg. Dist. No. 6

1. PLACE OF DEATH:

Baltimore

County

Baltimore City or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Paul

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W.

Married

6.(b) Name of husband or wife

Geraldine

7. Birth date of deceased (mo., day, yr.)

Sept 17, 1899

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

47

7

16

hrs. min.

9. Birthplace

Pa

(Town, county, and state)

10. Usual occupation

11. Industry or business

Bethlehem Steel

MOTHER FATHER

12. Name

Frank

13. Birthplace

Germany

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Geraldine Paul

Address

3426 Elm Ave

Date thereof 5-6-46

(Burial, cremation, or removal, which?)

Cemetery or crematory

Lorraine

Location

Baltimore

18. Funeral director

Frank J. Levy

Address

814 N. 39 St

Date 8/4/46

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

City or town

Baltimore

County

Street No.

3426 Elm Ave

Street

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3

19

46 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

and that I last saw h... alive on

Immediate cause of death

Coronary Occlusion

DURATION

40 min.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M.B. Davis M.D.
N.Y.C. Med. Exam - Board of other
Address: 123 Main St. Date signed: 5/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3rd

04629

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs

Hospital, institution, or street address where death occurred: 5008 Tulip ave

How long in hospital or institution?

3. (a) FULL NAME

Joseph Anthony Presogno

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

Male white Widowed

8. (b) Name of husband or wife

Emilia Ratalista

7. Birth date of deceased (mo., day, yr.)

Presson Sept 22 - 1861

8. AGE:

Years

Months

Days

If less than one day

84

7

27

hrs.

min.

9. Birthplace

Baltimore city

(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

Private Business

12. Name

John Presogno

13. Birthplace

Genoa Italy

14. Maiden name

Mary Presson

15. Birthplace

Genoa Italy

16. Informant

Miss Catherine Presogno

Address

5008 Tulip ave, Relay MD

17. Burial

Date thereof May 21/46

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Olivet

Location

Washington D.C.

18. Funeral director

Harry J. Kniffle

Address

4101 Edmondson av.

19. (Buyer, Registrar)

May 20 1946

Signature

Dr. Kieffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Baltimore

City or town.....

Relay

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

5008

Tulip ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 18 1946 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

of 12 1946 to 1946

and that I last saw him alive on May 18 1946

Immediate cause of death..

Myocarditis

Compensation

Due to General arteriosclerosis

Due to Arteriosclerosis

Severity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

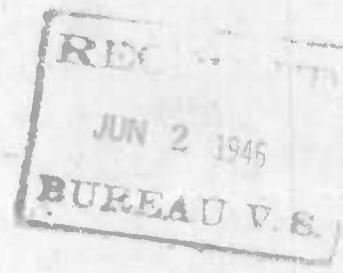
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

B. F. Brumbaugh M. D. or other

Address 5008 Main St. Elkhurst Date signed 5/18/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95d

04630

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

Baltimore

County.....

City or town.....

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 5 mos., 11 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 year, 5 mos., 11 days

3. (a) FULL NAME

Edward Peterson

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife -

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September 1861

8. AGE: Years Months Days If less than one day
84 8 ? hrs. min.9. Birthplace Harford County, Maryland
(Town, county, and state)

10. Usual occupation Painter, stone mason

11. Industry or business Building

12. Name Thomas Peterson

13. Birthplace ?

14. Maiden name Sally ?

15. Birthplace ?

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof June 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring Grove State Hospital
Location Catonsville 28, Maryland

18. Funeral director Spring Grove State Hospital

Address Catonsville 28, Maryland

19. June 6th 1946
(Date rec'd by registrar) Garrett Miller
Signature Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town ?
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1946 at 12:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. , to . 19.

and that I last saw h. alive on . 19.

Immediate cause of death

DURATION

Acute Cardiac failure

Due to

Cardio vascular disease

Other conditions Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 1010 Reade and Calvo

Date signed 5-23-46



authorization received
Lendon Brooks Funeral director

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:

County

Baltimore

City or town

Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Jane Powell II.

3. (b) Social Security Number

4. Sex

F

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Clarence Powell

7. Birth date of deceased (mo., day, yr.)

unKnown 1882

6. (c) If alive, give age

870 years

8. AGE:

63

Years

?

Months

?

Days

?

If less than one day

hrs.

min.

9. Birthplace

Balto. Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Charles Johnson

12. Name

Balto. Co. Md.

13. Birthplace

Sarah Jones

14. Maiden name

Balto. Co. Md.

15. Birthplace

Thomas Beard

Montgomery, Md.

16. Informant

Stephenson Chapel

Address

Sparks, Md.

17. Burial

Date thereof

May 19 1946

(Burial, cremation, or removal. Which)

Cemetery or crematory

Location

Means of injury

18. Funeral director

Address

John G. Green, M.D.

May 18

46 Wilmer C. Ensor

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Cockeysville

Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Cuba Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 16,

19

at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h... alive on

19

Immediate cause of death

Coronary Occlusion

DURATION

Due to

sudden death while

driving car.

sudden

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John G. Green, M.D. M. D. or other

Address: Lawyer, Md. Date signed: May 16/46

(Coroner's report)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 22 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

04632

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Lutherville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 20 years

Hospital, Institution, or street address where death occurred:

Burton Avenue.

How long in hospital or institution?.....

3. (a) FULL NAME

NANCY HARRIETT POWERS

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

September 24, 1889

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

11 less than one day

57 8 1 hrs. min.

9. Birthplace.....

Providence, Rhode Island

(Town, county, and state)

10. Usual occupation.....

Comptometer Operator

11. Industry or business

Gen. Acct. Office, U.S. Gov

MOTHER

FATHER

12. Name.....

Henry Powers

13. Birthplace.....

England

14. Maiden name.....

Flora MacKay

15. Birthplace.....

Novia Scotia

16. Informant..... Mrs. William H. Robinson

Address..... Burton Ave., Lutherville, Md.

17. Burial.....

(Burial, cremation, or removal. Which?) Date thereof May 28, 1946

(month) (day) (year)

Cemetery or crematory.....

Prospect Hill Cemetery

Location..... Towson, Maryland

18. Funeral director.....

John Burns' Sons

Address.....

Towson, Maryland

19. May 28, 1946

Wilmer C. Ensor

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Baltimore

City or town..... Lutherville

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Burton Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

216-05-9978

MEDICAL CERTIFICATION

May 25,

46

2:

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

3-9-46 46 to 5-25, 1946

and that I last saw her alive on 5-25, 1946

Immediate cause of death

Congestive Heart Disease

Due to Pulmonary Embolus Left

Due to Cerebral Embolus

Other conditions Thrombocytopenic Pancytopenia

DURATION

5 days

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

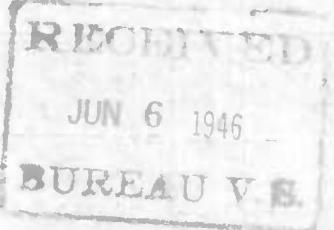
Means of Injury

Injured at work?

23. SIGNATURE

Bennett A. Stoen M. D. or other

Lutherville, Md. Date signed 5-25-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

04633
92
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Balto.

City or town.....

Bedford Ave -

Pikesville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

20 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife.....

Martha Belle Purdy

7. Birth date of deceased (mo., day, yr.)

Sept 25 - 1878

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Swanton, Ohio

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business.....

B & O. R.R.

12. Name.....

Dewight Purdy

13. Birthplace.....

Benton Huron Co. Ohio

14. Maiden name.....

Fannie J. Finks

15. Birthplace.....

Unknown

16. Informant.....

Martha B. Purdy

Address.....

Bedford Rd. Pikesville, Md.

17. Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

new Baltimore National

Cemetery or crematory.....

Frederick Rd & North Bend

Location.....

Frederick Rd & North Bend

18. Funeral director.....

Frank A. Yerrell

Address.....

Pikesville, Maryland

19. Date rec'd by registrar.....

J - 4 - 46 Dr E E Nichols

(Date rec'd by registrar)

new

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Balto.

City or town.....

Pikesville

Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Bedford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

Spanish American

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 2

1946 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2 1946 to May 2 1946

and that I last saw him alive on May 2 1946

Immediate cause of death.....

Bronchitis

DURATION

30 min.

Due to.....

Due to.....

Other conditions.....

Hypertension C.V. Disease

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur.....

(City or town) None (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

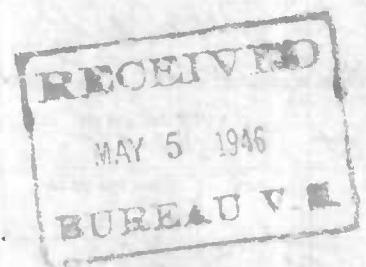
Injured at work?

23. SIGNATURE.....

A. D. Caples, M.D. Exam.

M. D. or other

Address..... Registerstown, Md. Date signed May 2 1946



UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1941

CERTIFICATE OF DEATH

04685

44

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town..... Middle River Baltimore 20
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos.

Hospital, institution, or street address where death occurred: Beech Dr. Box 60 Baltimore 20 Md. Middle River

How long in hospital or institution?

3. (a) FULL NAME

Frank T. Razy

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) March 4th 1854
6. (c) If alive, give age..... years

8. AGE: Years 92 Months 2 Days 22 If less than one day hrs. min.

9. Birthplace..... New York
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... Elmero Razy

13. Birthplace..... France

14. Maiden name..... Rebecca Tyler

15. Birthplace..... Unknown

16. Informant..... Mrs. Florence Wiltsie

Address Beech Dr. - Box 60. Baltimore Md.

17. Burial..... Date thereof..... May 29 1946
(Burial, cremation, or removal, which?) Cemetery or crematory..... Cedar Hill Cemetery

Location Prince George's Co. Md.

18. Funeral director..... Albert D. Duke

Address 641-H. 14 N.E. Washington D.C.

19. Date rec'd by registrar..... May 26 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)Street No..... 647-N. 14 St S
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 26th 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Tase 1946 to May 26 1946.

and that I last saw h. M. alive on May 24 1946.

Immediate cause of death..... Myocardial infarction

Due to..... Senility

Due to.....

Other conditions..... Generalized arteritis

Scleroses.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Thomas B. Hailey, M.D.
M.D. or other

Address..... 815 Eastern Ave. Date signed..... May 26 1946.

Baltimore Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92A

04636

CERTIFICATE OF DEATH

Reg. Dist. No.

1-Trau

1. PLACE OF DEATH:
County..... Baltimore County
City or town..... Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? March 7th, 1946 to May 11th, 1946
Hospital, Institution, or street address where death occurred: Vet. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 3-7-46 to 5-11-46

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
City or town..... Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1528 McKean Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war..... World War I

3. (a) FULL NAME
Frederick L. Reuschling

4. Sex..... Male	5. Color or race..... White	6.(a) Single, married, widowed, or divorced..... Married		
6.(b) Name of husband or wife..... Blanche Reuschling (wife)		6.(c) If alive, give age..... 57 years		
7. Birth date of deceased (mo., day, yr.)..... January 6th, 1889				
8. AGE:	Years..... 57	Months..... 4	Days..... 5	If less than one day
				hrs. min.
9. Birthplace..... Baltimore, Maryland	(Town, county, and state)			
10. Usual occupation..... Painter				
11. Industry or business				
12. Name..... Frederick Reuchling				
13. Birthplace..... Maryland				
14. Maiden name..... Catherine Dennis				
15. Birthplace..... Maryland				
16. Informant..... Clinical Records				

Address..... Vet. Adm. Fort Howard, Md.
Burial..... Burial
(Burial, cremation, or removal. Which?) Date thereof..... 5-15-1946
(month) (day) (year)
Cemetery or crematory..... Balti, national Cem.
Location..... Frederick Rd.
18. Funeral director..... Odell Funeral Home Inc
Address..... 4644 York Rd H-12.

19. Registrar..... 8 E. Jefferson
VS A15 9-45-15M

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 12 1946 at 4:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7th, 1946, to May 12, 1946,

and that I last saw him alive on May 12th 1946.

Immediate cause of death..... Heart Disease -- DURATION

Arteriosclerosis, aortic insufficiency, aortic stenosis, cardiac enlargement, myocardial insufficiency, heart block 1 year

Due to.....

Other conditions..... Hypertension, arterial 1 year

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Robert M. Cullison M. D. or other

R.M. CULLISON, M. D. Clin. Dir. 5-12-46

Address..... Vet. Hosp. Fort Howard Date signed..... Ma.

Registrar

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

P Reg. Dist. No.

83
04637

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore(b) City or town Preston

(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: No. Pleasant Preston(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2 years

(e) Length of stay in this community (yrs., mos., or days) _____

3 (a) FULL NAME Ervin Rice

3 (b) If veteran, name war

3 (c) Social Security

No. _____

4. Sex Male5. Color or race white6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife _____

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 19098. AGE: Years 37 Months 2 Days 16 If less than one day hr. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Bookkeeper

11. Industry or business

12. Name Abraham Rice13. Birthplace U.S.A.14. Maiden Name Minnie Stalvis15. Birthplace U.S.A.16 (a) Informant Abraham Rice(b) Address 3814 Norfolk Ave.17 (a) Casket (b) Date thereof May 30/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Bethel Cemetery18 (a) Funeral director J. C. Rice(b) Address 1419 E. 40th St.19 (a) 5/28/46 (b) 4428 Preston Rd.

(Date rec'd by registrar) (Date of death) Registrar

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Baltimore(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3814 Norfolk Ave.

(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. Date of death May 28, 1946, at 1:30 P.M.21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1939 to May 28, 1946, and that I last saw him alive on May 28 1946.

Immediate cause of death

Myocardial FailureDue to TuberculosisTuberculosisDue to Tubercular Empyema

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy For Advanced Pulmonary Tuberculosis

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Albert J. Shier M.D.

M. D. or other

Address Preston, Md. Date signed 5/28/46

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B-2*

CERTIFICATE OF DEATH

04638

Reg. Dist. No. 40

1. PLACE OF DEATH:

County... BaltimoreCity or town... White Marsh

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

Ebenezer Road

How long in hospital or institution?

3. (a) FULL NAME

BARBARA RIPKE

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

femalewhitewidowed6.(b) Name of husband or wife Frank Ripke6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) January 30, 18778. AGE: Years 69 Months 3 Days 21 If less than one day
hrs. min. 9. Birthplace Balto. Co., Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Herman Draayer13. Birthplace Balto. Co., Md.14. Maiden name Theresa Porter15. Birthplace Balto. Co., Md.16. Informant Mrs. John BowersAddress Philadelphia Road17. Burial May 23, 1946
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Holy Redeemer CemeteryLocation Balto. Md.18. Funeral director Parsons Funeral HomeAddress 7401 Belair Road19. *5/22/46* (Date rec'd by registrar)

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town White Marsh
(If outside city or town limits, write RURAL and give nearest town)Street No. Ebenezer Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 st,19. 46, at 4 *AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 4 1946 to April 4 1946and that I last saw her alive on April 4 1946

Immediate cause of death

Cerebral Haemorrhage

DURATION

3 mosDue to Hypertensive C-V disease

?

Due to Anterior cerebral arteriosclerosis

?

Other conditions Gen'l Atherosclerosis

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.H. Gilleman
M. D. or otherAddress Ridge Rd., Baet-6 Md. Date signed 5/21/46

RE

MAY 29 1946

BUREAU V.B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04639

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 days.

Hospital, institution, or street address where death occurred:

Veterans Administration Hospital

How long in hospital or institution?..... 2 days.

3. (a) FULL NAME

LAFAYETTE RITZ

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....

--

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 31, 1887

8. AGE:

Years

Months

Days

11 less than one day

58

9

25

hrs.

min.

9. Birthplace..... Baltimore, Md.

(Town, county, and state)

10. Usual occupation.....

Unemployed

11. Industry or business

MOTHER FATHER

August Ritz

12. Name..... Baltimore, Md.

13. Birthplace..... Baltimore, Md.

14. Maiden name..... ? Spaller

15. Birthplace..... Baltimore, Md.

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Fort Howard, Md.

17. Burial..... Date thereof..... May 29, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Loudon Park Cemetery

Location..... Baltimore, Md.

18. Funeral director..... Ullrich Funeral Home

Address..... 2008 Orleans St. Balto. Md.

19. (Date rec'd by registrar)

5/28/46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No..... 541 N. Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war..... World War

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 26

19 46 at 8:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 24

19 46

to May 26

19 46

and that I last saw h...im...alive on

May 26

19 46

Immediate cause of death.....

GASTRIC HEMORRHAGE, CAUSE UNDET.

DURATION

11 days

Due to.....

Due to.....

Other conditions..... Anemia, secondary to above 11 days

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

R. M. CULLISON, CLINICAL DIRECTOR

Address..... VAH, Fort Howard, Md. Date signed..... 5/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126

04640

P

CERTIFICATE OF DEATH

Reg. Dist. No. K3

1. PLACE OF DEATH:
 County Baltimore
 City or town Overlea
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, institution, or street address where death occurred: 11 E. Elm Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md County Baltimore
 City or town Overlea
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 11 E. Elm Ave.
 (If rural, give LOCATION)
 2.(a) Is veteran, name war? NO

3. (a) FULL NAME MARY SIEHLER ROSSMEISL

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Anton Rossmeisl

7. Birth date of deceased (mo., day, yr.) Aug 16 1873 6.(c) If alive, give age years

8. AGE:	Years	Months	Days	It less than one day
	72	8	25	hrs. min.

9. Birthplace Germany
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER	12. Name	<u>Frederick Siehler</u>
	13. Birthplace	<u>France</u>

MOTHER	14. Maiden name	<u>?</u>	<u>Wurst</u>
	15. Birthplace	<u>Germany</u>	

16. Informant Mr. Fred. G. Rossmeisl (Son)
 Address 11 E. Elm Ave. Overlea

17. Burial May 15, 1946
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory St. Matthew's Cem.

Location Baltimore Md.
 18. Funeral director HENRY SANDER & SONS, INC.
 Address North Ave. & Broadway. -13

19. 5-15 46 Aut. death
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1946 to 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 20 1946 to May 11 1946
 and that I last saw her alive on May 5 1946

Immediate cause of death Heart coronary dis.

DURATION 1 day
 Due to Myocarditis

Due to Cholecystitis

Other conditions Op cholecystectomy
 (Include pregnancy within 6 months of death)

Major findings of operations Gall stones
 Date of op. Apr 1/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE 6/11 May 46 M. D. or other

Address 1520 E. 32nd Date signed 5/12/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B72*

04641

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: Baltimore
 County.....
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 50 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 27 Wade avenue
 (If rural, give LOCATION)

3. (a) FULL NAME
 JOHN C. SCANNELL, Sr.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Margaret Lucey Scannell

7. Birth date of deceased (mo. day. yr.) June 10, 1860

8. AGE:	Years	Months	Days	It less than one day
	85	11	18	hrs. min.

9. Birthplace..... Ireland
 (Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... Cornelius Scannell

MOTHER FATHER
 12. Name..... Cornelius Scannell
 13. Birthplace..... Ireland

MOTHER
 14. Maiden name..... Johanna Sullivan

15. Birthplace..... Ireland

16. Informant..... Miss Margaret Scannell
 Address..... 27 Wade ave. Catonsville

17. Burial
 (Burial, cremation, or removal, Which?) Cathedral

Location.....
 18. Funeral director..... George J. Scannell Son Inc.

Address..... 118 W. Mt. Royal Ave.

19. 5-31 1946
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH: May 28 1946 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 24 1943 to May 28 1946 and that I last saw him alive on May 28 1946

Immediate cause of death: Cardiac fibrillation

Due to: Cardio-vascular renal disease

Other conditions:

DURATION: 2 wks

3. (b) Social Security Number

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

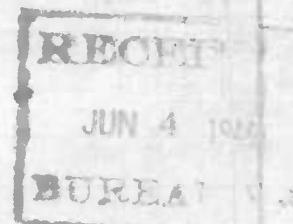
Means of injury..... Injured at work?

23. SIGNATURE: George J. Scannell MD
 M. D. or other

Date signed 5-28-46

Address..... Catonsville 28 MD

DR. URBAN
803 FREDERICK ROAD



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

04642

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

LENARD A. SCHAAR4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIEDB. (b) Name of husband or wife..... ESTELLA M. SCHAAR7. Birth date of deceased (mo., day, yr.) 8 JANUARY 1871 6. (c) If alive, give age 60 years8. AGE: Years 75 Months 4 Days 22 It less than one day * * * * * min. 009. Birthplace..... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER 12. Name..... Tobius Schaar13. Birthplace..... Germany14. Maiden name..... Caroline Pohlman15. Birthplace..... Maryland16. Informant..... Mrs. Estella M. SchaarAddress..... Gun Road, Elkridge, Md.17. Burial..... Loudon Park Cemetery Date thereof..... 3 June 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Baltimore, MarylandLocation..... O'Dell Thibault & Son
18. Funeral director..... 1300 Eutaw Place
Address.....19. June 1, 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... BaltimoreCity or town..... Elkridge (If outside city or town limits, write RURAL and give nearest town)Street No..... Gun Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... 30 MAY 1946 19..... at 10:10 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 18 19..... to May 30 19..... and that I last saw h. im. alive on May 30 19.....

Immediate cause of death.....

acute coronary occlusion of the left 2 daysDue to..... the myocarditis 3 moDue to..... coronary disease of right 5 yrs

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... B.B. Brumbaugh

M. D. or other.....

Address..... Elkridge, Md. Date signed 5/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

04643 56
Reg. Dist. No. P

1. PLACE OF DEATH:
County..... Baltimore

City or town..... Paradise
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Bonnie View Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

Mary E. Schneider

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... Charles Schneider

7. Birth date of deceased (mo., day, yr.)
Feb. 28, 1865

8. AGE:	Years	Months	Days	If less than one day
	81	2	27	hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... At home

11. Industry or business

12. Name..... August Limpert

13. Birthplace..... Germany

14. Maiden name..... Elizabeth Froehlich

15. Birthplace..... Maryland.

16. Informant..... August Schneider

Address..... 305 Greenwood Road,

17. Burial..... Date thereof..... May 28, 1946
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Loudon Park

Location..... Baltimore, Md.

18. Funeral director..... Ullrich Funeral Home

Address..... 2008 Orleans St.,

19. (Date signed by registrar) 7/28/46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 24 19 46 at M

21. I CERTIFY that death occurred on the date above stated; that deceased from June 15 19 45 to May 24 19 46 and that I last saw her alive on May 23 19 46.

Immediate cause of death
Arteriosclerosis & Hypertension

DURATION
2 yrs

Due to.... Arterialclerosis
Hypertension

Due to....

Other conditions.... Smoky

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Charles Cahn M.D.

M. D. or other.....

Address..... 2145 W. Balt H 7/28/46 Date signed.....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

04644

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: Baltimore
 County: Fork Md.

City or town: Fork Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William A Scott

4. Sex: M. 5. Color or race: W. 6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): Mar 25 - 1875 6. (c) If alive, give age: years

8. AGE: 71 Years 1 Months 0 Days If less than one day: hrs. 0 min.

9. Birthplace: Ind.
 (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

12. Name: James Scott

13. Birthplace: Ind.

14. Maiden name: Ann E Mooney

15. Birthplace: Ind.

16. Informant: Susie R. Scott

Address: Burial Ind. Date thereof: MAN 17 1946

17. (Burial, cremation, or removal, Which?) Cremation Date thereof: (month) (day) (year)

Cemetery or crematory: Fork M. Cem.

Location: Fork Md.

18. Funeral director: C. E. Arthur

Address: Fork Md.

19. May 16 1946 C. E. Arthur
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: MD. County: Baltimore

City or town: Fork Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No.:
 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 - 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that deceased from

Oct. 10, 1945, to May 14, 1946

and that I last saw him alive on May 14, 1946

Improbable cause of death: Repetitedly vomited from R. Axilla 1 wk.

Due to: Epithelioma of V. Thymus 1 yr.

with metastasis to arm,

Due to: chest wall & lung

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

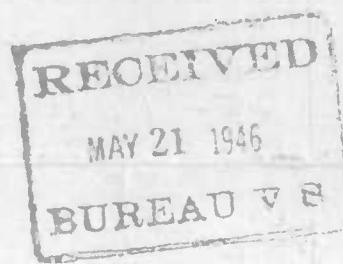
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE:

Gifford F. Hudson, M.D. M. D. or other

Address: Fork Md. Date signed: 5/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

04645 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County..... Baltimore
City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 20 Years
Hospital, Institution, or street address where death occurred:..... 630 Orpington Rd.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md. County..... Baltimore
City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 630 Orpington Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME
William A. Scott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Mary Scott

7. Birth date of deceased (mo., day, yr.)..... June 13, 1867
B.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
78 11 12 hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)

10. Usual occupation..... Machinist-Retired

11. Industry or business..... P. R. R.

MOTHER FATHER
12. Name..... Wm. A. Scott

13. Birthplace..... Howard Co., Md.

14. Maiden name..... Ellen ?

15. Birthplace..... Howard Co., Md.

16. Informant..... Mrs. Mary Scott

Address..... 630 Orpington Rd, Baltimore 29

17. Burial
(Burial, cremation, or removal. Which?) Date thereof..... May 28, 1946
Cemetery or crematory..... Loudon Park Cem.

Location..... Baltimore, Md.

18. Funeral director..... Wm. J. Tickner & Sons, Inc.

Address..... North & Penn Aves. Balto, 17 Md.

19. 5/22/46
(Date rec'd by registrar)

A. W. Hedrich
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 25 1946 at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1946, to May 25, 1946, and that I last saw him alive on May 25, 1946.

Immediate cause of death..... Myocarditis (Chronic)
DURATION..... 5 years

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

23. SIGNATURE..... Eugene S. Passano

M. D. or other

Address..... 514 Spring St. Date signed..... 5/27/46

Dr. Eugene Pessagno
513 Drury Lane

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

04646

Reg. Dist. No. 31

1. PLACE OF DEATH

County

City or town

Baltimore
Randallstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept 17th 1877

6. (c) If alive, give age

years

8. AGE:

Years

Months

8

Days

6

If less than one day

hrs.

min.

9. Birthplace

Randallstown

(Town, county, and state) Md.

10. Usual occupation

11. Industry or business

William Sellers

12. Name

Mary Louise Sellers

13. Birthplace

England

14. Maiden name

Mary Jane Coats

15. Birthplace

Baltimore

16. Informant

Mrs. W. O. Phillips

Address

9 E Church Road, Randallstown Md.

17. Burial

Date thereof

May 10 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cemetery

Location

Randallstown

Md.

18. Funeral director

S. Phillips

American

Address

5450 Liberty Heights Ave

19. (Date rec'd by registrar)

5/20/46

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Randallstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

9

East Church Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 18th 1946 at 2⁴⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 17th 1946 to May 17th 1946, and that I last saw her alive on May 17th 1946.

Immediate cause of death

Cancer of the breast

DURATION

1 yr

Due to

Melastoma

Due to

arterio hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Thor Abbott

M. D. or other

Address 4509 Liberty Heights Ave Date signed 5/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

04647
57

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Cockeysville (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or Institution?.....

3. (a) FULL NAME

Mary Elizabeth Sheeler

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Charles E. Sheeler

6. (c) If alive, give age..... 71 years

Dec. 19, 1880

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

60

6

12

hrs.

min.

9. Birthplace.....

Balto Co. Maryland

(Town, county, and state)

10. Usual occupation.....

Homemaker

11. Industry or business

MOTHER FATHER

12. Name.....

Bradley Sheeler

13. Birthplace

Balto Co. Md.

14. Maiden name.....

Mary Harrington

15. Birthplace

Balto Co. Md.

16. Informant.....

Charles E. Sheeler

Address

Cockeysville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... June 2 - 46

(month) (day) (year)

Cemetery or crematory.....

Ashland Presbyterian

Location.....

Ashland, Balto Co., Md.

18. Funeral director.....

Landon M. Brooks

Address

Sparks

June 1, 46

Wilmer C. Ensor

19. (Date rec'd by registrar).....

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Baltimore

City or town.....

Cockeysville

(Rural)

Street No.....

Sheerwood Rd

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 31 1946 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

19.....

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of Injury

Injured at work?

23. SIGNATURE

T.C. de Quincey Lee

M. D. or other

Address.....

Cockeysville - Md

Date signed..... May 31 1946

RECEIVED

JUN 4 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

910-FLORRIDA
13c 04648 P
30

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:
 County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 10 days
 Hospital, institution, or street address where death occurred:
 Opitz Nursing Home
 How long in hospital or Institution?..... 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 3042 Windsor Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Annie Elizabeth Sherwood

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
female	white	widowed		
6.(b) Name of husband or wife..... Wilbur				
7. Birth date of deceased (mo., day, yr.) Sept. 22, 1870				
8. AGE:	Years	Months	Days	If less than one day
	75	7	23	hrs. min.
9. Birthplace..... Baltimore <small>(Town, county, and state)</small>				
10. Usual occupation..... Housewife				
11. Industry or business				
FATHER	12. Name..... Milton Frank			
MOTHER	13. Birthplace..... Baltimore, Maryland			
	14. Maiden name..... Sarah Colbert			
	15. Birthplace..... Baltimore, Maryland			
16. Informant..... Mrs. Gertrude F. Garrett				
Address..... 415 Birch Place, Westfield, N. J.				
17. burial..... Date thereof..... 5/17/46 <small>(Burial, cremation, or removal. Which?)</small> (month) (day) (year)				
Cemetery or crematory..... Parkwood				
Location..... Baltimore County, Maryland				
18. Funeral director..... William Cook, Incorporated				
Address..... 1217 St. Paul Street				
19. 5/17/46 <i>Dukedumb</i> <small>(Date rec'd by registrar)</small>				

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 15 1946 at 9A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 May 8 1946 to May 15 1946
 and that I last saw h..... alive on May 15 1946

Immediate cause of death..... Cerebral Hemorrhage
 DURATION 1 mo

Due to..... Cerebral Hemorrhage
 DURATION 1 mo

Due to..... 20 seconds
 DURATION 1 mo

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... *Annie Elizabeth*
 M. D. or other

Date signed 11-16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 461

04049

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County

Balto

City or town

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Dixie Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

Blanche E. Smith

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband or wife

John J. Smith

7. Birth date of deceased (mo., day, yr.)

Jan

1884

6.(c) If alive, give age years

8. AGE:

Years
62

Months

Days

If less than one day

hrs. min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

(Unknown)

Etzburger

13. Birthplace

"

14. Maiden name

"

15. Birthplace

"

16. Informant

Hazel Motis (Friend)

Address

534 E. North Ave

17. Burial

Date thereof
(month) (day) (year)
5/23/46

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Balto

Location

" Md.

18. Funeral director

William Cook Inc

Address

1217 St. Paul St.

19. (Date rec'd by registrar)

5/21/46

1946

A.W. Hedrich

Registrar
DM

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Balto

City or town

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Nunney Lane Clarendon Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 19th 1946 15 21 5 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1946 to May 19 1946

and that I last saw h. alive on May 19 1946

Immediate cause of death

Peritonitis & Perforation of Rectum

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Jesse Estowee

Acorn Ocean

5/20 Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04650

CERTIFICATE OF DEATH

Reg. Dist. No.

30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		Baltimore County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		
		8 months, 3 days How long in above place of death?		
		Hospital, Institution, or street address where death occurred: Spring Grove State Hospital How long in hospital or institution? 8 months, 3 days		
3. (a) FULL NAME		MARGARET Mary Smith A		
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced female white widowed		
6. (b) Name of husband or wife		Elmer Elsworth Smith		
7. Birth date of deceased (mo., day, yr.)		December 18, 1864 6. (c) If alive, give age..... years		
8. AGE:	Years 81	Months 4	Days 29	If less than one day hrs. min.
9. Birthplace		Baltimore, Maryland (Town, county, and state)		
10. Usual occupation		Housewife		
11. Industry or business		Home		
FATHER	12. Name			John Kronester
MOTHER	13. Birthplace			Germany
	14. Maiden name			Margaret Rhinehart
	15. Birthplace			Germany
16. Informant		Hospital records		
Address		Catonsville-28, Md.		
17. Burial		Date thereof	5/20/46 (Burial, cremation, or removal, which?)	
Cemetery or crematory		Mt Carmel		
Location		Balto. Md.		
18. Funeral director		William Cook Inc.		
Address		1217 St. Paul St.		
19. (If not by registrar)		5/20 1946	A. W. Hedrick DM	Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Baltimore County.....
City or town..... Baltimore-5
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 403 N. Curley Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1946 at 2:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 1945 to May 17 1946

and that I last saw her alive on May 17 1946

Immediate cause of death
Pneumonia, left lower lobeDURATION
17 das.Due to
Hypertensive cardiovascular cerebral disease

Indef.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 5-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4820

CERTIFICATE OF DEATH

04652

30

Reg. Dist. No.

1. PLACE OF DEATH:

County.....Balto.City or town.....Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

7 Overbrook Rd.

How long in hospital or Institution?.....

3. (a) FULL NAME

BESSIE BLANCHE SPICKNALL

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife.....Thomas F. Spicknall7. Birth date of deceased (mo., day, yr.).....June 5, 1887 6.(c) If alive, give age years8. AGE: Years Months Days If less than one day
58 11 15 hrs. min.9. Birthplace.....Seaford, Del. (Town, county, and state)10. Usual occupation.....Housewife

11. Industry or business

12. Name.....James Hargus Hutson13. Birthplace.....Delaware14. Maiden name.....Margaret Jennings Smith15. Birthplace.....Delaware16. Informant.....Mr. Thomas F. Spicknall
Address.....7 Overbrook Rd., Catonsville17. Burial.....Burial Date thereof.....5/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....Woodlawn Cem.Location.....Woodlawn, Md.18. Funeral director.....WM. J. TICKNER & SONSAddress.....Balto., Md.19. Sh. 3 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....Balto.City or town.....Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....7 Overbrook Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 20, 1946 at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 19, 1945 to May 20, 1946and that I last saw h. w. alive on May 19 - 1946

Immediate cause of death.....

Gastritis & ulcer
varix & adnexaDURATION.....6 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....as above Date of op. Feb. 1946

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Mrs. Anna and Hood M. D. or other.....Address.....2200 Garrison Blvd. Date signed 5-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

04653

Reg. Dist. No. 32

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Baltimore
 City or town Cockland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Blanche Alberta Staines

3. (b) Social Security Number

4. Sex

Female

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Howard Hayes (Staines)

7. Birth date of deceased (mo., day, yr.)

December 8-1868

6. (c) If alive, give age years

8. AGE:

Years 77 Months 4 Days 25 If less than one day hrs . min.

9. Birthplace

Baltimore Co. Maryland

(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

William Halbert (HALBERT)

12. Name

Maryland

13. Birthplace

Sarah P. Burnett

14. Maiden name

Maryland

15. Birthplace

Mrs. Carrie B. Stuller

16. Informant

1303 Appleby Avenue

Address

Burial

17. (Burial, cremation, or removal. Which?)

Prospect Hill Cemetery

Date thereof May 6-1946
 (month) (day) (year)

Cemetery or crematory

Towson, Maryland

Location

Burgee Funeral Home

18. Funeral director

1363 Falls Road

Address

574 Ks

19. Registrat

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Cockland If outside city or town limits, write RURAL and give nearest townStreet No. Falls Road If rural, give LOCATION

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3rd 1946 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1936 to May 3rd 1946and that I last saw her alive on May 3rd 1946

Immediate cause of death

Chronic Myocarditis 2 yrs.

Due to

Hypertension 10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

James J. Gillen Jr. M.D. or other

Pleasantville, Md. Date signed 5/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1066

CERTIFICATE OF DEATH

Reg. Dist. No. 046538

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jessie Blake Stanbury

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White married
 Henry L. Stanbury

6.(b) Name of husband or wife..... Henry L. Stanbury

6.(c) If alive, give age..... 68 years

7. Birth date of deceased (mo. day, yr.)

Nov. 19 1875

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Baltimore City Md.
 (Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

MOTHER FATHER

12. Name..... Jessie Blake L.

13. Birthplace..... Calvert Co. Md.

14. Maiden name..... Jessie Kyle

15. Birthplace..... Cincinnati Ohio

16. Informant..... Mr. Henry L. Stanbury

Address

27 1/2 Planna Ave. Towson Md.
 BurialDate thereof..... 5/29/46
 (month) (day) (year)

Cemetery or crematory.....

Druid Ridge Cemetery

Location.....

Pikesville Md.

18. Funeral director..... John O' Malley Sons

Address

1900 Eutaw Pl. Baltimore Md.

19. May 28 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltimore

City or town..... Towson (If outside city or town limits, write RURAL and give nearest town)

Street No. 27 W. Planna Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

May 26 1946 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 24th 1946 to May 26 1946
 and that I last saw her alive on May 26 1946

Immediate cause of death.....

Acute Cardiac Collapse

Due to..... Hypertension and heart failure

and chronic bronchitis

Due to.....

DURATION

2 yrs.

2 yrs.

2 yrs.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

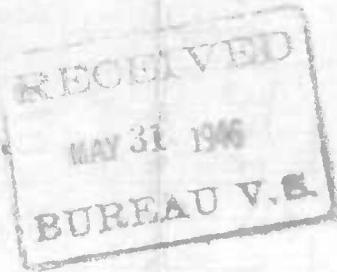
Injured at work?

23. SIGNATURE..... Daniel O' Malley

M. D. or other

Address..... Towson Md.

Date signed..... Sept 16



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04655

04655

38

P

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Sept 1, 1943

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since Sept 1, 1943

3. (a) FULL NAME

Beatrice Anne Steltz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FemalewhiteMarried6. (b) Name of husband or wife Williams A. Steltz6. (c) If alive, give age 73 1/2 years

7. Birth date of deceased (mo., day, yr.)

June 11, 1916

8. AGE:

Years 30Months 11Days 1If less than one day
hrs. 0 min. 0

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

12. Name

Artie Lang Daly

13. Birthplace

Baltimore, Md.

14. Maiden name

Elois Ellis

15. Birthplace

Baltimore, Md.

Personal History- Hospital Records

16. Informant

Eudowood Sanatorium, Towson 4, Md.

Address

Eudowood Sanatorium, Towson 4, Md.

17. Burial

Data thereof 5/15/46

(Burial, cremation, or removal, When?)

(month) (day) (year)

Cemetery or crematory

Western Cemetery

Location

Eudowood Edmondson Ave.

John Howard & Son

18. Funeral director

John Howard & Son

Address

904 03 Hollins St.

19. Date rec'd by registrar

5/13/46

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore (If outside city or town limits, write RURAL and give nearest town)Street No. 1310 Sergeant (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1946 21. 145921. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1, 1943 to May 12, 1946 and that I last saw her alive on May 11, 1946.

Immediate cause of death

Pulmonary Tuberculosis Since March 1940

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W.A. Bridges M. D. or other

Towson 4, Maryland Date signed 5-12-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

04656 P

CERTIFICATE OF DEATH

Reg. Dist. No. *3d*

1. PLACE OF DEATH:

Baltimore
Catoonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *7 months*

Hospital, institution, or street address where death occurred: *Spring Grove State Hospital*

How long in hospital or institution? *7 months*

3. (a) FULL NAME

Gertrude ~~Stine~~ Stine

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife.....

8.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) *September 4 1926*

8. AGE:	Years	Months	Days	If less than one day
	19	8	21hrs.min.

9. Birthplace *Garrett Co. Maryland*
(Town, county, and state)

10. Usual occupation *None*

11. Industry or business *"*

12. Name *John William Stine*

13. Birthplace *Baltimore, Maryland*

14. Maiden name *Cydney Wilburn*

15. Birthplace *Maryland*

16. Informant *Hospital Records, Spring Grove State*

Address *Hospital, Catoonsville, 28, Md*

17. Burial *Burial* Date thereof *5/28-46*
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Western*

Location *Edmondson Ave*

18. Funeral director *Edward Souton*

Address *2859 Wash Blvd*

19. *5/27/46 Autopsy*

Registrar *Henry C. A. Mead, M.D.*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Baltimore*

City or town *Halethorpe*
(If outside city or town limits, write RURAL and give nearest town)

Street No. *2824 Ridge Avenue*
(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH *May 25th 1946* 19..... at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *October 26, 1945* 19..... to *May 25 1946* 19.....
and that I last saw her alive on *May 25th 1946* 19.....

Immediate cause of death *Mitral Stenosis* DURATION *Indef.*

Due to *Subacute Bacterial Endocarditis* "

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE *Henry C. A. Mead, M.D.* M. D. or other

Address *Catoonsville, 28, Md.* Date signed *5/26/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

04657

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County BaltimoreCity or town Glyndor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Howard Hewitt Stockdale

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W. W.

6. (b) Name of husband or wife

Katherine A K Carl.

7. Birth date of deceased (mo., day, yr.)

May 25, 1873

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

72.1123

hrs.

min.

9. Birthplace

Riverside, Balt. Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

John Thomas C. Stockdale

12. Name

Mother Father Dumb Knob

13. Birthplace

Eliza Cook

14. Maiden name

Dumb Knob

15. Birthplace

Carpenter

16. Informant

Carlynn K. Simonds

Address

Glyndor

17. Burial

(Burial, cremation, or removal. Which?) Date thereof May 20, 1946

(month) (day) (year)

Cemetery or crematory

Trinity Lutheran

Location

Riverside

18. Funeral director

Mr. Berryman & Sons

Address

Riverside

19. Date rec'd by registrar

5-29

19-46

Date signed

B. E. Line

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County BaltimoreCity or town Glyndor, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 - State worth Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

Lost

MEDICAL CERTIFICATION

20. DATE OF DEATH

5/18/46 19 60. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-5-30 19 5-17-46 19 to 5-17-46 19and that I last saw him alive on 5-17-46 19

Immediate cause of death

Myocarditis - Thromb
decompensating

DURATION

2 yrs

Due to

Angina pectoris
Arteriosclerosis

Due to

Chronic nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

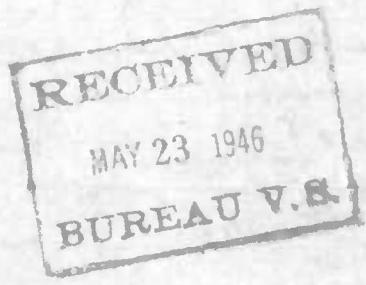
23. SIGNATURE

L. Saffell M.D.

M. D. or other

Address

Riverside May 20, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

04658
Reg. Dist. No. 81. PLACE OF DEATH: Baltimore

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Albert George Struven

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.M.widow/w

6.(b) Name of husband or wife

Amelia Geff

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 5 1852

8. AGE:

Years Months Days If less than one day

94066

hrs.

min.

9. Birthplace

Bremenhaven Germany

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Peter Struven

FATHER

12. Name

Holland or Germany (border)

13. Birthplace

Sophia Zukem

14. Maiden name

Holland or Germany (border)

15. Birthplace

Bertha Struven Deller

16. Informant

Address

706 Joppa Rd. Towson Md

17. Burial

Date thereof

(month) (day) (year)

Cemetery or crematory

Lorraine

Location

Balt. Ind. Woodlawn

18. Funeral director

Henry M. Jenkins, H. M. Jenkins

Address

McCullough & Grahams

May 22 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

Balt.

City or town

Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

706 W Joppa Rd

(If farm, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 st 1946 at 8 45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 21 st 1944 to May 21 1946and that I last saw h. m. alive on May 19 th 1946

Immediate cause of death

Old Age

DURATION

Due to Generalized arteriosclerosis -

40 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Tor. F. Seefeld M. J. M. D. or otherAddress 200 W. Penna. Ave. Date signed 5/21/46

R.D.C. 1946

JUN 2 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

04659

Reg. Dist. No. 30

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County BaltoCity or town Gatonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

204 Shady Nook Court, Gatons

How long in hospital or institution?

3. (a) FULL NAME

Sophia R. Samuels

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White MarriedHarry L.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. - 13 - 1877

8. AGE:

Years

Months

Days

If less than one day

6875

hrs.

min.

9. Birthplace

10. Usual occupation

(Town, county, and state)

now

11. Industry or business

12. Name

John Lengenart

13. Birthplace

Germany

14. Maiden name

Mary Louise

15. Birthplace

Germany

16. Informant

Mrs. Charles BrumleyAddress 304 Shady Nook Court

17. Burial

Date thereof May 26-46
(month) (day) (year)Cemetery or crematory London ParkLocation Balto, Md.

18. Funeral director

George A. FarleyAddress Fred. & Shady Nook Ave. Balto19. 5-2019. 46Address Harry Miller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County BaltoCity or town Gatonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 Shady Nook Court

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1946 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 25 1942 to May 18 1946and that I last saw her alive on May 17 1946

Immediate cause of death

Pseudo myxoma peritonei

DURATION

Due to

Due to

Other conditions

arteriosclerosis, Caries?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

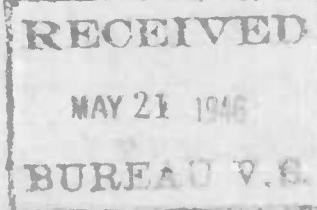
Injured at work?

23. SIGNATURE

Carey Roskru

M. D. or other

Address 1326 W Lombard StDate signed 5/20/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12

CERTIFICATE OF DEATH

Reg. Dist. No.

04669
38

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since May 7, 1946

Hospital, Institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since May 7, 1946

3. (a) FULL NAME

Frances Zymanowski

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

6. (b) Name of husband or wife

Theodore Zymanowski

6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.)

Jan. 1919

8. AGE:

Years Months Days If less than one day
27 4

hrs. min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Stapley Maluzynski

12. Name

Stanley Maluzynski

MOTHER FATHER

13. Birthplace Poland

14. Maiden name

Augusta Bigut

15. Birthplace Poland

Personal History - Hospital Records

16. Informant

Eudowood Sanatorium, Towson 4, Md.

Address

Burial Date thereof 6-15-46

(Burial, cremation, or removal. Which?)

Cemetery or crematory St. Stanislaus

Location Baltimore, Md.

18. Funeral director George A. Weber

Address 705 S. Ann St

19. 5-13 46 On Medical

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore City

City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 5738 Bethel (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

215-07-1693

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1946 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 7, 1946, to May 11, 1946

and that I last saw her alive on May 7, 1946

Immediate cause of death

Pulmonary tuberculosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?

Means of injury

Injured at work?

23. SIGNATURE

W.A. Bridgeman

M. D. or other

Towson 4, Maryland Date signed 5-11-46

Address

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

04661

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

Baltimore

County

Catoonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs., 7 mos., 7 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 10 yrs., 7 mos., 7 days

3. (a) FULL NAME

John Tilsch

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Bertha Freid

6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) December 28, 19038. AGE: Years Months Days If less than one day
42 6 - hrs. min.9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Cab driver

11. Industry or business Taxi

12. Name ?

13. Birthplace ?

14. Maiden name ?

15. Birthplace ?

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof June 21, 1946
(Burial, cremation, or removal. Whch?)

(month) (day) (year)

Cemetery or crematory Spring Grove State Hospital

Location Catonsville 28, Maryland

18. Funeral director Spring Grove State Hospital

Address Catonsville 28, Maryland

19. June 21 1946 Harry Miller
(Date signed by registrar) Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1404 East Baltimore Street

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1946 at 12:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1946 to May 28 1946

and that I last saw him alive on May 28 1946

Immediate cause of death

Myocardial insufficiency,
chronic, with heart block

DURATION

Indef.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

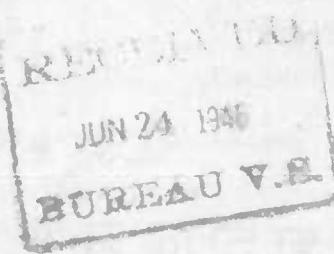
Means of injury

Injured at work?

23. SIGNATURE Isadore Tuerk, M.D.

M. D. or other

Address Catonsville-28, Md. Date signed 6-20-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

04662

CERTIFICATE OF DEATH

Reg. Dist. No. 3d

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 9 days

3. (a) FULL NAME archibald
Archie ain

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 2 South Patterson Park

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

widowed

B.(b) Name of husband or wife.....?

6.(c) If alive, give age..... years

7. Birth date of
deceased (mo., day, yr.)

December 8, 1875

8. AGE:

Years

Months

Days

If less than one day

70

5

15

hrs.

min.

9. Birthplace.....

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

?

12. Name.....

?

13. Birthplace

?

14. Maiden name.....

?

15. Birthplace

?

16. Informant.....

Hospital records

Address

Catonsville-28, Md.

17. Burial
(Burial, cremation, or removal. Which?)Date thereof.....
(month) (day) (year)

May 27th 1946

Cemetery or crematory

Balto. bourn

Location

E North Ave Eit

of G. bourn

18. Funeral director.....

Geo G. bourn

Address 1701-03 N Patterson Park Ave

19. 5-27 1946
(See page 2 for registrar)

1946

Harry J. Miller
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 23 1946, at 12:35 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 14 1946, to May 23 1946

and that I last saw him alive on May 23 1946

Immediate cause of death.....

Pulmonary oedema

Cachexia

Due to..... Cerebral arteriosclerosis

Due to.....

Other conditions..... Right hemiplegia

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

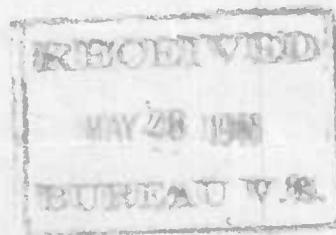
Means of injury.....

Injured at work?

Isadore Fuerk, M.D.
Signature

M. D. or other

Address..... Catonsville-28, Md. Date signed..... 5-24-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04663

Reg. Dist. No.

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Owings Mills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs. 5 mos. 25 days

Hospital, institution, or street address where death occurred:

Rosewood State Training SchoolHow long in hospital or institution? 7 yrs. 5 mos. 25 days

3. (a) FULL NAME

Alberta Vance

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white single

6. (b) Name of husband or wife.....

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 16. 1920.

8. AGE:

Years

Months

Days

If less than one day

25 11 17 hrs. min.

9. Birthplace.....

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

12. Name..... William G. Vance13. Birthplace Baltimore County, Md.14. Maiden name Margaret Ely15. Birthplace Baltimore, Md.16. Informant Rosewood State Training SchoolAddress Owings Mills, Md. Records17. Burial Burial Date thereof 5/7/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CathedralLocation Baltimore City18. Funeral director C. W. DawsonAddress 444 Park Heights19. 5-6 1946 (Date rec'd by registrar)Last signed by
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore CityCity or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5216 Florence Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1946, at 11:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8, 1945, to May 3, 1946, and that I last saw her alive on May 3, 1946.

Immediate cause of death.....

acute myocarditis
& pulmonary edema

DURATION

1 wk.12 hrs.

Due to.....

Chronic myocarditis and
endocarditis

7 yrs. 5 mos.

Due to.....

admission
Pulmonary Tuberculosis

2 yrs. 10 mos.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isabel H. McClintic M.D.
M. D. or otherAddress Rosewood Owings Mills Date signed May 4, 1946
Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04664

P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
 County..... Baltimore
 City or town..... Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 123 Days

Hospital, Institution, or street address where death occurred: Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution?..... 123 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... 702 Bradley Street, Balto, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... See Above
 (If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

3. (a) FULL NAME

FREDERICK WALTON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband/wife..... Elizabeth Walton

7. Birth date of deceased (mo., day, yr.)..... 8-10-1889

6.(c) If alive, give age..... 56 years

8. AGE: Years	Months	Days	If less than one day
56	9	2	hrs. min.

9. Birthplace..... Virginia
 (Town, county, and state)

10. Usual occupation..... Plaster Work

11. Industry or business

12. Name..... Robert Walton

13. Birthplace..... Virginia

14. Maiden name..... Martha Hall

15. Birthplace..... Virginia

16. Informant..... Clinical Records, Vets. Adm. Hosp.
 Ft. Howard, Maryland

Address

17. Burial..... Date thereof..... 5-15-46
 (Burial, cremation, or removal, Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory..... Mt. Zion Cem.

Location..... Baltimore Co. Md.

18. Funeral director..... Mrs. Frances A. Hendley

Address..... 578 W. Biddle St.

Address..... (Date rec'd by registrar)

Date signed..... 5-13-46

MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 12, 1946, at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 1946, to May 12, 1946.

and that I last saw him alive on May 12, 1946.

Immediate cause of death..... Carcinoma of Stomach

DURATION..... Unknown

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Biopsy of Cervical lymph node..... Carcinoma of stomach

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Robert M. Cullison

R.M. CULLISON, M.D. CIN. M.D. or other

Address..... Ft. Howard, Md. Date signed..... 5-13-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

04665 27
Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Baltimore County, Md.

City or town: Kingsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Donald W Washburn

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) July 2, 1927
6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day hrs. min.

9. Birthplace: Wentworth, N. Hampshire
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U.S. Army

12. Name: Claude J. Washburn

13. Birthplace: Wytoplach, Maine

14. Maiden name: Violet Smith

15. Birthplace: Dublin, N. Hampshire

16. Informant: Army Records

Address: Fort George G. Meade, Md.

Removal Date thereof: 5/27/46
(Burial, cremation, or removal. Which?)

Cemetery or crematory: Rosedale & Swann

Location: Woodsville, N. Hampshire

18. Funeral director: Howard W. Blight Jr.

Address: 4914 Belair Road.

19. Date rec'd by registrar: 27 May 46

ALIAN G. BROTHMAN, 2d Lt., Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New Hampshire County:

City or town: Glen Cliff
(If outside city or town limits, write RURAL and give nearest town)

Street No.: If rural, give LOCATION

2.(a) If veteran, name war:

3. (b) Social Security Number

003-12-4315

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1946 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on May 19, to May 19,
and that I last saw him alive on May 19,

Immediate cause of death: Cerebral hemorrhage

possibly fractures, skull and neck

Due to: Auto Accident

DURATION: 5/25/46

5/25/46

Due to: Auto Accident

5/25/46

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Ruptured heart with hemopericardium

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Auto accident Date of: 5/25/46

Where did injury occur? Kingsville, Baltimore, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) RT-1

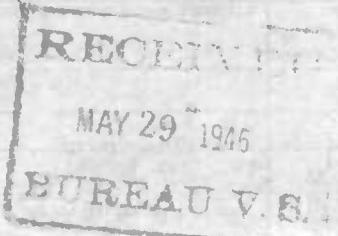
Means of Injury: Auto accident Injured at work? No.

23. SIGNATURE

Rollin B. Huber, M.D., D.M.E. M. D. or other

Address: Towson 4, Md. Date signed: 5/25/46

MAC.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

04666 42
Reg. Dist. No.

1. PLACE OF DEATH:
 County..... Baltimore
 City or town..... Arbutus
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death.....
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

FLORENCE E. WEIBER

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married
B.(b) Name of husband or wife..... Joseph A. Weiber		
7. Birth date of deceased (mo., day, yr.)..... 18 th. July 1896		
6.(c) If alive, give age..... 54 years		

8. AGE: Years	Months	Days	If less than one day
49	9	28	***** min.

9. Birthplace..... Baltimore Maryland
 (Town, county, and state)
 Housewife

10. Usual occupation..... At Home

11. Industry or business.....

FATHER 12. Name..... William H. Stienwedel

MOTHER 13. Birthplace..... Baltimore Maryland

14. Maiden name..... Estelle T. Woody

15. Birthplace..... Baltimore, Maryland

16. Informant..... Mr. Joseph A. Weiber

Address..... 916 Elmridge Road

Burial 17. (Burial, cremation, or removal. Which?) Date thereof..... 20 May 1946
 Cemetery or crematory..... Loudon Park Cemetery

Location..... Baltimore, Maryland
A. F. Wilkens & Son

Funeral director..... 1300 Eutaw Place

Address..... 5120 46 Dr. Howard
 (Date rec'd by registrar).....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland State..... Baltimore
 City or town..... Arbutus
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 916 Elmridge Road
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
 NONE

MEDICAL CERTIFICATION
 16th. May 46

20. DATE OF DEATH..... 19 at 430 P.M.
 21. I CERTIFY that death occurred on the date above stated. That I attended deceased from November 22 45 to May 16 46
 and that I last saw her alive on May 9 45.

Immediate cause of death..... Hypertension C. V. Cns
 DURATION (1941) years

Due to..... Acute Cardiac Dilatation 1/2 hour

Due to.....

Other conditions..... Acute Pulmonary edema 2 days
 (Cause of death)

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE (Dr. I. Earl Pass) Earl Pass M.D.
 Address..... 4001 Wilkins Ave. M. D. or other
 Date signed..... 5/1/46 \$46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

Reg. Dist. No. 44

0466744

1. PLACE OF DEATH: Baltimore - 19-
 County Sparrows Point
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred
2605 Lodge Farm Rd.
 How long in hospital or institution?

3. (a) FULL NAME
THURMOND CORBETT.

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mabel Page West.

7. Birth date of deceased (mo., day, yr.) May 8, 1918. 6. (c) If alive, give age 29 years

8. AGE: Years 27 Months 11 Days 24 It less than one day — hrs. — min.

9. Birthplace Nicholas Co. W. Va. (Town, county, and state)

10. Usual occupation Shipfitter

11. Industry or business Shop building

12. Name Arthur West.

13. Birthplace Charles Co. Va.

14. Maiden name Katie Shafer

15. Birthplace Charles Co. Va.

16. Informant Mabel West

Address Address as in #1

17. Removal Burial Date thereof 5/21/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Charlottesville

Location Charlottesville, Va.

18. Funeral director John J. Connolly

Address 418 Lestern Ave. Suite 21,

19. 5/21/46 (Date rec'd by registrar) John J. Connolly

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State MD County Howard
 City or town 20 ea #1 (If outside city or town limits, write RURAL and give nearest town)
 Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war —

3. (b) Social Security Number 223-18-8170

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to May 1, 1946.

and that I last saw him alive on April 23, 1946.

Immediate cause of death Pulmonary Tuberculosis

DURATION 4 yrs.

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

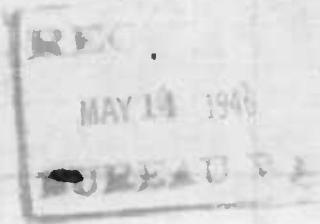
Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Louis J. Pollin, M.D. M. D. Other —

Address Sparrows Point, Md. Date signed May 1, 1946



SEARCHED
INDEXED
SERIALIZED
FILED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 981

04668

CERTIFICATE OF DEATH *

Reg. Dist. No.

32

1. PLACE OF DEATH:

County Baltimore

City or town Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

JOHN HENRY WINTER

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Oct 31, 1864

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

81

7

20

hrs.

min.

9. Birthplace.....

Baltimore

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

FATHER

Frank Winter

MOTHER

Germany

13. Birthplace

Germany

14. Maiden name

Louisa H. Laes

15. Birthplace

Germany

16. Informant

Mrs. Charles L. Schenck

Address

110 Church Lane, Pikesville, Md.

17. Burial

Date thereof: May 22-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

New Cathedral

Location

Edmondson Ave.

18. Funeral director

Frank H. Mead

Address

Pikesville, Maryland

19. Date rec'd by registrar

5-22-1946

Dr. E. E. Nichols

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

110 Church Lane

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 20, 1946, at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19, 1946, to May 20, 1946,

and that I last saw him alive on May 19, 1946.

Immediate cause of death

Heart Failure

Due to

Chronic Myocarditis

Due to

Generalized Arteriosclerosis

Other conditions

Senility

DURATION

4 days

()

Years

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Deane

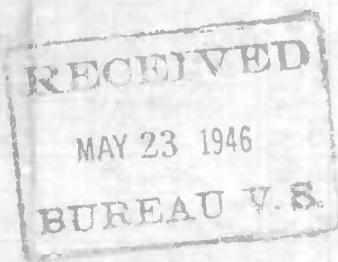
1413 Restoration Rd

M. D. or other

Address

Pikesville

Date signed 5/20/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

P
04669

CERTIFICATE OF DEATH

Reg. Dist. No.

I. PLACE OF DEATH:

County.....*Baltimore*City or town.....*Owlesa*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*2 days*Hospital, Institution, or street address where death occurred:.....*Elmwood*

How long in hospital or institution?.....

3. (a) FULL NAME

John Philip Wertz

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

*Male**White**Single*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Nov 11th

6.(c) If alive, give age years

1885

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Baltimore

(Town, county, and state)

10. Usual occupation.....

Clerk

11. Industry or business

B & O RR

12. Name.....

John P. Wertz

13. Birthplace.....

Germany

14. Maiden name.....

Christina Sauer

15. Birthplace.....

Germany

16. Informant.....

James W. Wertz

Address.....

7048 Linwood Ave

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof (month) (day) (year)

Cemetery or crematory.....

Baltimore Cem

Location.....

City

18. Funeral director.....

Wertz

Address.....

1008 Orleans St

19. (Date rec'd by registrar)

5/30/46

19. (Date rec'd by registrar)

5/30/46

D. W. Blech

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Balto

City or town.....

40 Owlesa

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

4503 Linwood Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 29

1946, at 6:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 22 1946 to *May 28 1946*and that I last saw h. m. alive on *May 28* 1946

Immediate cause of death.....

Coronary occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE

D. W. Blech

M. D. or other

Address.....*1123 St. Paul St.* Date signed *5/30/46*

M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BS*04670
44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Baltimore County
 City or town... Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12-26-45 to 5-10-46

Hospital, institution, or street address where death occurred:

Veterans Administration, Fort Howard, Md.How long in hospital or institution? 12-26-45 to 5-10-46

3. (a) FULL NAME

Roland H. Wright

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife	Nina Wright
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7. Birth date of deceased (mo., day, yr.)	March 7, 1923	6.(c) If alive, give age	22 years
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8. AGE:	Years	Months	Days	If less than one day
	23	2	4	hrs. min.

9. Birthplace... Middle River, Maryland
(Town, county, and state)

10. Usual occupation... Unemployed

11. Industry or business

12. Name	(Deceased) William Wright
----------	---------------------------

13. Birthplace	Baltimore, Md.
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14. Maiden name	Annie Lovell
-----------------	--------------

15. Birthplace	Virginia
----------------	----------

16. Informant... Clinical Records

Address	Veterans Administration, Fort Howard, Md.
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17. Burial	Date thereof..... <u>5-15-46</u> <small>(Burial, cremation, or removal. Which?)</small>
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Cemetery or crematory	<u>Forest Glen Cemetery</u>
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Location	<u>Eastern Ave</u>
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18. Funeral director	<u>Adel Funeral Home Inc.</u>
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Address	<u>4644 York Rd #12</u>
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19. (Date read by registrar)	<u>5/18/46 Dec 1946</u>
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2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore, Md.City or town... Essex, Md. (If outside city or town limits, write RURAL and give nearest town)Street No.... Box # 234 # 13, Cape May Road

(If rural, give LOCATION)

2.(a) If veteran, name war... World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 11, 1946 19. 46 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26th 19. 46 to May 11 19. 46

and that I last saw him alive on May 11th 19. 46

Immediate cause of death... Cerebral EmbolismDuration... 2 weeksDue to... Subacute Bacterial Endocarditis
5 monthsDue to... Rheumatic Heart Disease
6 monthsOther conditions...
(Include pregnancy within 3 months of death)Major findings of operations...
Data of op.Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Robert M. Cullison M.D. or other

R. M. BULLISON, M.D. Clin. Dir. 5-12-46

Date signed

Address... Veterans Hospital, Fort Howard, Md.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 111871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:	
(a) Baltimore City, Maryland	
(b) Street address.....	
(c) Hospital or institution: <i>Sparrows Pt. Shipyard</i>	
(d) Length of stay in hospital or inst. (yrs., mos., or days) <i>doa</i>	
(e) Length of stay in Baltimore (yrs., mos., or days).....	
3 (a) FULL NAME <i>John Zeitvogel</i>	
3 (b) If veteran, name war <i>None</i>	3 (c) Social Security Account No. <i>.....</i>
4. Sex <i>Male</i>	5. Color or race <i>white</i>
6 (a) Single, married, widowed, or divorced. <i>married</i>	
6 (b) Name of husband or wife <i>Anna Braun</i>	
6 (c) If alive, give age years <i>July 29, 1901</i>	
7. Birth date of deceased (mo., day, yr.)	
8. AGE: Years <i>44</i>	Months
Days <i>less than one day</i>	
hr. min.	
9. Birthplace <i>Austria</i> (Town, county, and state)	
10. Usual Occupation <i>Engineer Dredge</i>	
11. Industry or business <i>Standard Oil Co</i>	
MOTHER / FATHER	12. Name <i>anton Zeitvogel</i>
	13. Birthplace <i>Austria</i>
14. Maiden Name <i>Elizabeth Prinz</i>	
15. Birthplace <i>Austria</i>	
16 (a) Informant <i>Mrs Anna Zeitvogel</i>	
(b) Address <i>6031 Old Harford Rd</i>	
17 (a) Burial <i>Burial</i> (b) Date thereof <i>15/8/46</i> (Burial, cremation, or removal) (month) (day) (year)	
(c) Cemetery or crematory Location <i>New Cathedral Old Frederick Rd</i>	
18 (a) Funeral director <i>Harry Hulchko</i>	
(b) Address <i>4101 Edmondson Ave</i>	
19 (a) <i>5 - 8 - 46</i> (b) <i>Accidental Drown</i> (Date rec'd by registrar) Registrar	

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County.....
(c) City or town *Baltimore*
(If outside city or town limits, write RURAL, and give town)
(d) Street No. *6031 Old Harford Rd*
(If rural give location)
(e) Citizen of foreign country? *Yes*, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH *5-6-1946*, at *9 A.M.*

21. I certify that I took charge of the remains described above, held an *autopsy* thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary or contributing cause of death, fill in the following:

- (a) Date of injury *5-6-46* at *?* M.
(b) Where did injury occur? *Pier I: Sparrows Pt.*
(c) Did injury occur at home, on farm, industrial place, in public place? *Public* While at work? *?*
(d) Means of injury *Found drowned*

23. Signature *H. H. & M.D.*
Medical Examiner
Date signed *5-7-46*

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

04672

30

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Baltimore
 County: Catonsville
 City or town: Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
 Hospital, institution, or street address where death occurred: 101 Ingleside Ave.
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Baltimore
 City or town: Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 101 Ingleside Ave.
 (If rural, give LOCATION)

3. (a) FULL NAME

4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Regina F.

7. Birth date of deceased (mo., day, yr.): June 6, 1892

7. Birth date of deceased (mo., day, yr.): June 6, 1892 8. AGE: Years: 53 Months: 11 Days: - If less than one day: hrs. - min.

9. Birthplace: Catonsville, Md.
 (Town, county, and state)

10. Usual occupation: Sexton
 11. Industry or business: St. Timothy Church
 12. Name: George Zimmerman
 13. Birthplace: Unknown
 14. Maiden name: Catherine Kilbaugh
 15. Birthplace: Unknown

16. Informant: Mrs. Regina Zimmerman
 Address: 101 Ingleside Ave., Catonsville, Md.

17. Burial: Burial Date thereof: May 9, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Old Fred Rd., Balt., Md.

18. Funeral director: Easton Sons

Address: 608 Fred Ave., Catonsville, Md.

19. 5-8- 1946 Harry J. Miller
 (Date rec'd by registrar) Deputy Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1946 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1945 to May 6, 1946, and that I last saw him alive on May 6, 1946.

Immediate cause of death: Chronic myocarditis DURATION 5 yrs.

Due to: Arterio-sclerosis DURATION 5 yrs.

Due to: Hypertension DURATION 5 yrs.

Other conditions: _____

(Include pregnancy within 8 months of death)

Major findings of operations: none Date of op. _____

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: _____

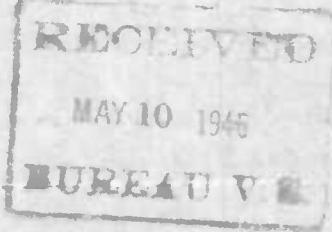
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: Injured at work Injured at work? _____

23. SIGNATURE: McHerring, M.D. M. D. or other _____

Address: 101 Ingleside Ave., Catonsville, Md. Date signed: 5/7/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 526

04673

CERTIFICATE OF DEATH

Reg. Dlat. No. 38

1. PLACE OF DEATH:

County.....Balto.City or town.....Parkville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....10 yrs.

Hospital, Institution, or street address where death occurred:

5107 Dalesford Rd.

How long in hospital or institution?

3. (a) FULL NAME

Frank C. Zinsler

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male white Married6.(b) Name of husband or wife.....Angela M. Zinsler7. Birth date of
deceased (mo., day, yr.)Aug. 27 1890

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

55 9 3 hrs. min.

9. Birthplace.....

Balto Md.
(Town, county, and state)

10. Usual occupation.....

Chef Ktcr

11. Industry or business

Standard Oil Co. N.J.

12. Name.....

Geo V. Zinsler

13. Birthplace

Balto. Md.

14. Maiden name

Caroline Trans

15. Birthplace

Germany

16. Informant

Mrs. Frank C. Zinsler

Address

8107 Dalesford Rd.

17. Burial

Data thereof.....6 8 46
(Burial, cremation, or removal. Which?)
(month) (day) (year)Cemetery or crematory.....Moreland Memorial ParkLocation.....Balto. Co. Md.18. Funeral director.....LaSalle Funeral HomeAddress.....7401 Belair Rd.

19. 6-1

19.46 G.M. Bacon
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md.County.....Balto.City or town.....Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....8107 Dalesford Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 30th 1946 A.P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 5th 1946 to May 30 1946
and that I last saw him alive on May 30 1946

Immediate cause of death.....

Carcinoma Bladder

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....Carcinoma Date of op.1/20/46

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?(City or town)(County)(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE.....J.S. Hardung MD

M. D. or other

Address.....48-0 Belair Rd. Date signed May 31/46

Dr J S Hardinge

4810 Belair Rd



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04674

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH:

County

Baltimore

City or town

Blossom Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

26 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Frank Valentine Zoeller

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widower

8. (b) Name of husband or wife

Lydia E. Zoeller

7. Birth date of deceased (mo., day, yr.)

June 26, 1865

6. (c) If alive, give age years

8. AGE: Years

89

Months

10

Days

78

If less than one day

hrs. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Brick Layer

11. Industry or business

FATHER

Frank Zoeller

MOTHER

Mary F. Steckfuss

13. Birthplace

Baltimore, Md.

14. Maiden name

15. Birthplace

Mrs. Albert Fischer

16. Informant

Address

Blossom Park

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 6, 1946
(month) (day) (year)

Cemetery or crematory

New Cathedral

Location

Baltimore, Md.

18. Funeral director

G. Howard Strong

Address

3707 W. North Ave.

19. (Date rec'd by registrar)

Signature

A. C. S.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

City or town

Blossom Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Everhart Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3

46

17.30

P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 3, 1946, to May 3, 1946

and that I last saw him alive on May 3, 1946

Immediate cause of death

Coronary Occlusion

DURATION

1 hour

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. C. S.

SMINK

M. D. or other

Address: 4509 Lombard Ave. Date signed: May 4